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HERTFORDSHIRE COUNTY COUNCIL

the health of hertfordshire

The Report of the County Medical Officer
Dr. G. W. Knight, M.D., D.P.H.



1972

COUNTY HALL,
HERTFORD,

November, 1973

To the Chairman and members of the health committee and the education committee

LADIES AND GENTLEMEN,

I have the honour to present the report on the local authority's health services and school health services for the year 1972. As always I am indebted to the officers of the department who prepare these annual reports but particularly so at this moment in time when they not only have to carry out their routine duties but are also required to absorb additional work in preparation for reorganization of health services.

The philosophy adopted in the department has been to encourage delegation of administrative responsibility both to officers in divisions and to individual officers employed at headquarters. Although this has resulted in comparatively low costs attributable to administration (e.g. the number of medical administrators employed at headquarters is now reduced to two) it has also increased the pressures on the senior staff and there is little doubt that some are feeling the strain. To the relatively small number of senior administrators there appears to be no respite from the additional work loads they are required to carry in order to deal with a rapidly changing scene in the health and social service fields. Reorganization of local authority social services could not be effected overnight nor without the direct involvement of the staff of the health department. Continuing responsibility for the management of certain social services until such time as they could be satisfactorily transferred to the Social Services Department was accepted knowing that reorganization of health services was inevitable and would make further demands on the staff, the extent of which could not be measured. Needless to say the need to send health administrators on full-time courses of training in preparation for the integration of national health services has added to the problems of maintaining an effective administration.

I cannot speak too highly of the staff both at headquarters and at divisional level for, over a number of years, they have accepted disruption in their working routines beginning with the reorganization of the department in order to integrate health and welfare services followed subsequently as a result of Government legislation by a further reorganization in order to separate health and social service administration, and now by the decision to reorganize health services outside local government. Bearing in mind that at this moment of writing few, if any, of them are clear what the future has in store when they cease to be employed as local government officers in 1974, it is only right and proper that this tribute should be paid and their loyalty and dedication recognized. Not unnaturally little opportunity presented itself during the year to do much more than maintain existing patterns of service and we must look to post 1974 years for any changes designed to utilise the resources of the national health service more effectively. Any changes however would come gradually for there is little doubt that it will take some time, possibly up to two years, for the Hertfordshire Area Health Authority to design and finally put into effect a completely new management structure. Emphasis must be given therefore to the transfer of health services to this new authority with the least possible disruption and without detriment to the public. Having said this it is inevitable that the future working relationships between health services and local government services, e.g. social and educational services, should be suspect to some, for the patterns of administration of these related services are not identical. It remains to be seen what benefits the general public obtain from the separate and

independent management of these community services but a great deal will depend on the ability of both members and officers to disregard departmental and professional interests whenever circumstances warrant it. The county council's concern to see an effective and comprehensive health service linked closely with its social and educational services should be in no way diminished simply because the council ceases to have direct responsibility for the management of health services. An understanding of the problems and complexities of integrating what are at present three independent branches of the health service is vital if co-operation between the authorities is to be achieved.

This is of particular importance during the formative years of the new Area Health Authority when both members and officers alike will be embroiled in the not insignificant task of creating a completely new organization and management structure.

My experience with the county council leads me to believe that this interest and understanding will be forthcoming and that representation by local government members on health authorities; on joint consultative committees and on community health councils provides the opportunities of joint involvement in the future development of integrated health services and of co-ordinated health and social services in Hertfordshire.

It remains for me to thank once more the staff of the department for the work they have undertaken during the year and the members for the support they give. I trust the report will be read with interest.

I am, Ladies and Gentlemen,
Your obedient servant,

G. W. KNIGHT,

County Medical Officer.

COMMITTEES

Health committee.

Chairman—County Alderman Mr. H. L. Morbey.

Vice-Chairman—County Councillor Mrs. H. J. Doherty.

Members of the county council.

Mrs. J. Alderton	R. Parsons
E. A. Bennett	F. G. Peacock
C. W. Bowsher	K. C. Piggott
Mrs. W. A. Boyd	D. L. G. Richardson
Mrs. H. J. Doherty	Mrs. J. Simons
J. H. F. Fryd	V. J. Stanley
Mrs. E. M. Hales	Mrs. I. E. Stebbings
Mrs. M. M. Harvey	Mrs. N. L. Thompson
E. C. W. Huson	A. G. Vincent
T. C. H. Irwin	Mrs. H. S. Walduck
H. L. Morbey	

The Chairman and Vice-Chairman of the county council and Chairman and Vice-Chairman of social services committee are *ex officio* members.

There are, in addition, 11 members nominated by various organizations.

Education committee.

Chairman—County Alderman Mr. A. D. Sheridan.

Vice-Chairman—County Alderman Mr. W. A. Hill.

Members of the county council.

D. G. Ashworth	P. T. Ireton, D.L.
K. W. Baker	G. H. Kaufmann
The Hon. Lady Bowes-Lyon	Capt. V. Lamb, C.B.E.
Mrs. W. A. Boyd	Mrs. H. M. Lawrence
P. L. Burgin	J. H. Lewis
Mrs. A. D. J. Calnan	R. Little
F. J. Cogan	Miss L. A. M. Lloyd-Taylor
G. K. Dickens	H. L. Morbey
Mrs. H. J. Doherty	D. F. O'Connor
Mrs. I. Dunn	L. C. Parker
W. J. Edwards	Dr. P. W. Roe
J. H. F. Fryd	A. D. Sheridan
Mrs. E. M. Hales	Mrs. V. Sparrow
W. A. Hill	Mrs. N. L. Thompson
E. A. A. Hitch	Mrs. W. M. Walshe
F. G. Hunt	C. Selly

There are, in addition, 23 members nominated by various organizations.

Special services sub-committee.

Chairman—County Alderman Miss L. A. M. Lloyd-Taylor.



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I Vital statistics

Summary of statistics, 1972

	<i>Hertfordshire.</i>	<i>England and Wales.</i>
Area (acres)	403,797	
Population (Registrar General's mid-1972 estimate)	940,630	49,028,900
Rateable value	£60,533,124	
Product of a new penny rate	£1,449,372	
<i>Live births.</i>		
Number	13,445	
Rate per 1,000 population (crude)	14.3	14.8
Area comparability factor	0.98	
Rate per 1,000 population (adjusted)	14.0	
Illegitimate live births (per cent of total live births)	5.7	8.6
<i>Stillbirths.</i>		
Number	160	
Rate per 1,000 live and stillbirths	11.8	12.0
Total live and stillbirths	13,605	
<i>Infant mortality.</i>		
Infant deaths (deaths under the age of 1 year)	180	
Total infant deaths per 1,000 total live births	13.4	17.2
Legitimate infant deaths per 1,000 legitimate live births	12.8	16.9
Illegitimate infant deaths per 1,000 illegitimate live births	22.4	21.1
Neonatal mortality rate (deaths under age of 4 weeks per 1,000 total live births)	9.1	11.5
Early neonatal mortality rate (deaths under the age of 1 week per 1,000 total live births)	8.0	9.8
Perinatal mortality rate (stillbirths and deaths under the age of 1 week combined per 1,000 total live and stillbirths)	19.6	21.7
<i>Maternal mortality (including abortion).</i>		
Number of deaths	None	
Rate per 1,000 total live and stillbirths	0	0.15
<i>Deaths.</i>		
Number of deaths from all causes	8,917	
Death rate per 1,000 population (crude)	9.5	12.1
Area comparability factor	1.11	
Death rate per 1,000 population (adjusted)	10.5	

Births

The total number of live births during the year was 13,445, giving a crude birth rate of 14.3 per 1,000 and a standardized rate of 14.0 compared to a rate for England and Wales of 14.8. (The birth rate was the lowest since 1941.)

Population

The estimated population at 30th June was 940,630. The natural increase in population (excess of births over deaths) was 4,528, the lowest increase in the last 10 years. The age structure of the population is young compared with the national population, 10.2 per cent of the population of the county being over 65 years of age compared with 12.9 per cent nationally.

Deaths

The number of deaths during the year was 8,917, 4,407 men and 4,510 women. This gave a crude death rate of 9.5 per 1,000 and a standardized death rate of 10.5 compared with 12.1 for England and Wales. The death rate in 1972 was slightly higher than in 1971 both in Hertfordshire and in England and Wales (Hertfordshire 1971: 10.2, England and Wales 1971: 11.6). There were no specific reasons for these increases, just a general increase in many of the causes of death.

Abortion

In 1972 there were 1,933 legally induced abortions on Hertfordshire residents. This compares with 1,682 in 1971. The 1972 rate for Hertfordshire of 8.6 per 1,000 women aged 15-49 is slightly lower than the national rate of 9.9 per 1,000 women aged 15-49.

Deaths of infants

During the year there were 180 deaths in infants under the age of 1 year. 123 of these were under 4 weeks of age and 57 between the ages of 4 weeks and 12 months. The infant mortality rate was 13.4 compared to the national rate of 17.2. Most of the causes of death were due to birth injury, difficult labour, and congenital abnormalities.

Other deaths

There were 212 deaths in children under 5 representing 2.4 per cent of all deaths and 4,118 deaths (46.2 per cent of all deaths) in people aged over 75. At all ages death rates were higher in men than women.

The five most common causes of death in men were:—

	<i>Number</i>
Ischaemic heart disease	1,209
(coronary thrombosis)	
Cancers	1,013
Cerebro-vascular diseases	420
Pneumonia	349
Chronic bronchitis	298

In women, the five most common causes of death were:—

Cancers	926
Cerebro-vascular diseases	834
Ischaemic heart disease	810
Pneumonia	417
Heart diseases, other than Ischaemic heart disease	268

There were 39 deaths from communicable diseases during the year, including 14 from tuberculosis.

Fatal accidents

There were 91 deaths from road accidents and 194 deaths from other accidents (accidents at home and at work). There were 159 deaths from other accidents in 1971. Non-fatal injuries caused by road accidents were 4,412 and there were 1,577 home accidents which were attended by the ambulance service during the year.

Ischaemic heart disease

The death rate from this disease continued to increase. This was the most common cause of death in men, but in 1972 dropped from second to third cause of death in women. The death rate in males in 1972 was 261.7/100,000 and 169.2/100,000 in females. Death rates from this disease were higher in men at all ages and in men there were increases in the death rate at age 35-44 (from 26.2/100,000 in 1971 to 65.1/100,000 in 1972), and in men aged 45-54 (from 210.5/100,000 in 1971 to 239.5/100,000 in 1972). The causal factors in this disease are not finally sorted out, but the following factors may be involved: increasing age; men more vulnerable than females at all ages; women become more vulnerable after the menopause; inherited abnormalities of lipo-proteins in a small group of people; cigarette smoking; obesity and too little physical exertion. In some geographical areas of Britain soft water appears to play a part in deaths from this disease (but not in Hertfordshire, where the water is hard).

Cancer of the lung

The welcome decrease of deaths from lung cancer which occurred in 1971 did not continue in 1972. There were 534 deaths (421 men, 113 women, death

rate 56·8/100,000) in 1972 compared with 467 deaths (death rate 50·7/100,000) in 1971. The major cause of lung cancer is cigarette smoking, and these figures reflect the failure of health education to persuade people to give up smoking.

Cancer of the breast

This is the commonest cause of cancer deaths in women. In 1972, 226 women (death rate 47·2/100,0000) died of breast cancer in the county. There has been an upward trend in the death rate from this disease in Hertfordshire over the last 10 years. The Hertfordshire death rate is very similar to the national death rate.

Cancer of the cervix

There were 34 deaths (death rate 7·1/100,000) from cancer of the cervix in the county in 1972, and the death rate has changed little over the last 5 years. Hertfordshire death rates are lower than the national rates, but this could be due to the younger age composition of Hertfordshire's population compared with the national population.

Prevalence and control of infectious disease

Measles

Measles was the most common notifiable communicable disease during 1972. Before 1968, when measles vaccination was introduced, large measles outbreaks occurred every other year, the last of such outbreaks with 14,736 cases occurring in 1967. Since the introduction of measles vaccination the incidence of measles has been greatly reduced with 3,372 cases in 1968, 2,205 in 1969, 3,118 in 1970, 2,529 in 1971, and 948 in 1972.

Whooping cough

There were 49 cases of whooping cough, compared with 207 cases in 1971, which was the highest number of notifications since 1968.

Tuberculosis

There were 103 cases of pulmonary tuberculosis and 28 cases of other forms of tuberculosis notified during the year. The incidence of this once common disease continued to fall. In 1961 there were 276 cases of pulmonary and 48 other forms of tuberculosis notified.

Other notifiable infectious diseases

No cases of diphtheria, poliomyelitis or smallpox occurred during the year. There was 1 death from typhoid which was contracted overseas, and 6 deaths from acute meningitis.

Vital statistics—Tables and figures

General statistics

Area in acres	403,797
Population (Registrar General's mid-1972 estimate)	940,630

Table 1 Population—Age and sex composition 1972 (estimated)

<i>Age.</i>	<i>Males.</i>	<i>Females.</i>	<i>Total.</i>
0-4	37,350	35,720	73,070
5-14	83,060	78,580	161,640
15-64	304,840	305,280	610,120
65 and over	36,670	59,130	95,800
	<u>461,920</u>	<u>478,710</u>	<u>940,630</u>
Rateable value			£60,533,124
Product of a new penny rate			£1,449,372

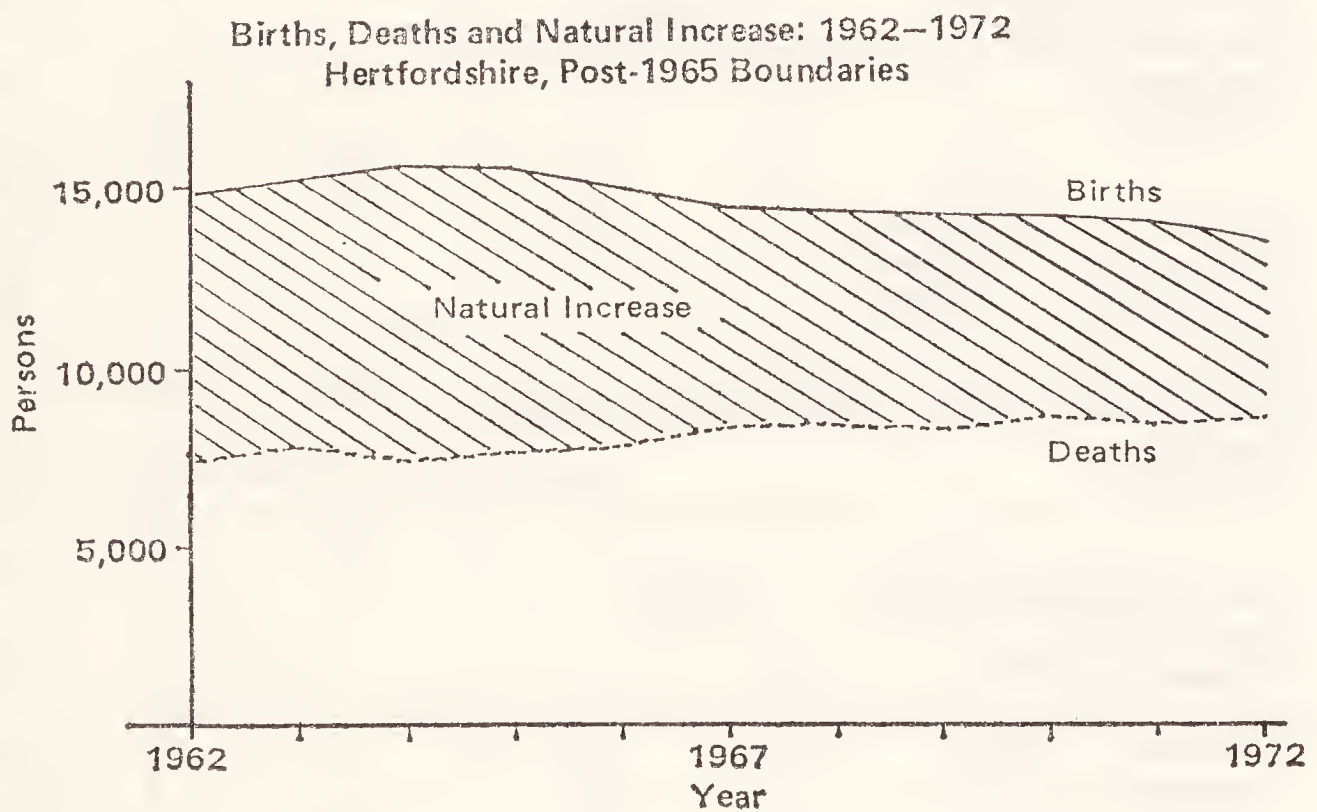
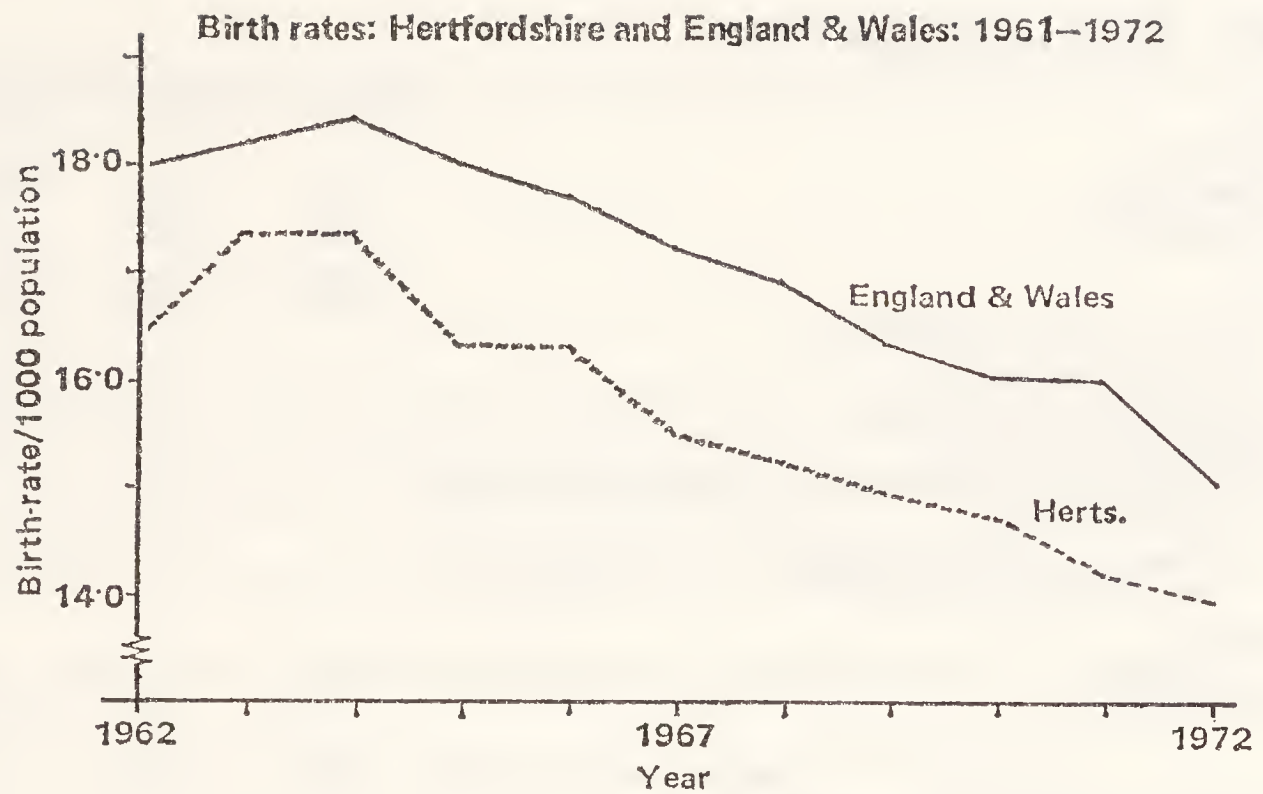


Table 2 Population Hertfordshire—Births, deaths, birth rates crude and adjusted 1962/1972

Year	Mid-year population	Live Births	Deaths	Natural increase	Adj. B. rate	England & Wales B. rate
1962 . . .	857,200	15,598	8,207	7,391	16.37	18.0
1963 . . .	873,870	16,011	8,453	7,558	17.40	18.2
1964* . . .	892,390	16,328	7,930	8,398	17.37	18.4
1965 . . .	860,970	15,586	7,805	7,781	16.3	18.0
1966 . . .	872,100	15,008	7,961	7,047	16.3	17.7
1967 . . .	881,870	14,572	7,828	6,744	15.5	17.2
1968 . . .	892,470	14,477	8,477	6,000	15.2	16.9
1969 . . .	903,390	14,300	8,219	6,081	14.9	16.3
1970 . . .	912,000	14,269	8,737	5,532	14.7	16.0
1971 . . .	930,390	14,062	8,336	5,726	14.2	16.0
1972 . . .	940,630	13,445	8,917	4,528	14.0	14.8

* Boundary changes took place with a reduction in size of the county.

Table 3 Vital statistics, 1972

	<i>Males.</i>	<i>Females.</i>	<i>Total.</i>
<i>Live births.</i>			
Legitimate	6,396	6,289	12,685
Illegitimate	403	357	760
	<hr/> 6,799	<hr/> 6,646	<hr/> 13,445
Rate per 1,000 Population—			
Hertfordshire (crude) . . . . .	.	.	14.3
Hertfordshire (adjusted) . . . . .	.	.	14.0
England and Wales . . . . .	.	.	14.8
Hertfordshire illegitimate live births per cent of total live births			
	.	.	5.7
England and Wales illegitimate live births per cent of total live births			
	.	.	8.6
<i>Stillbirths.</i>			
Legitimate	72	74	146
Illegitimate	6	8	14
	<hr/> 78	<hr/> 82	<hr/> 160
Rate per 1,000 live and stillbirths :			
Hertfordshire . . . . .	.	.	11.8
England and Wales . . . . .	.	.	12.0
<i>Infant deaths</i> (deaths under the age of 1 year) :			
Legitimate	102	61	163
Illegitimate	7	10	17
	<hr/> 109	<hr/> 71	<hr/> 180
Rate per 1,000 live births :			
Hertfordshire : legitimate . . . . .	.	.	12.8
Hertfordshire : illegitimate . . . . .	.	.	22.4
Hertfordshire : combined . . . . .	.	.	13.4
England and Wales : combined . . . . .	.	.	17.2
<i>Neo-natal deaths</i> (deaths under the age of 4 weeks) :			
Legitimate	71	42	113
Illegitimate	4	6	10
	<hr/> 75	<hr/> 48	<hr/> 123
Rate per 1,000 live births :			
Hertfordshire . . . . .	.	.	9.1
England and Wales . . . . .	.	.	11.5
<i>Early neo-natal deaths</i> (deaths under the age of 1 week) :			
Legitimate	61	37	98
Illegitimate	4	5	9
	<hr/> 65	<hr/> 42	<hr/> 107
Rate per 1,000 live births :			
Hertfordshire . . . . .	.	.	8.0
England and Wales . . . . .	.	.	9.8
<i>Perinatal deaths</i> (stillbirths and deaths under the age of 1 week) :			
Legitimate	133	111	244
Illegitimate	10	13	23
	<hr/> 143	<hr/> 124	<hr/> 267
Rate per 1,000 live and stillbirths :			
Hertfordshire . . . . .	.	.	19.6
England and Wales . . . . .	.	.	21.7
<i>Maternal mortality</i> (including abortion) :			
Number of deaths . . . . .	.	.	None
Rate per 1,000 live and stillbirths . . . . .	.	.	—
<i>Deaths from all causes.</i>			
Males . . . . .	.	.	4,407
Females . . . . .	.	.	4,510
	<hr/>	<hr/>	<hr/>
Total . . . . .	.	.	8,917
Rate per 1,000 population :			
Hertfordshire (crude) . . . . .	.	.	9.5
Hertfordshire (adjusted) . . . . .	.	.	10.5
England and Wales . . . . .	.	.	12.1

	Males.	Females.	Total.
<i>Deaths from cancer</i> (all forms) :			
Males	1,013
Females.	926
Total	1,939
Rate per 1,000 population	2.06

Comparability factors.

In view of the differing age and sex distribution of local populations, the General Register Office supplies factors for adjusting the birth and death rates to enable comparisons to be made with the rates for other areas and the country as a whole. In addition, the death rate area comparability factor is adjusted to take account of the presence of any residential institution in the area.

The comparability factors for Hertfordshire are : births 0.98 and deaths 1.11.

Table 4 Abortions, Hertfordshire and England and Wales, 1969–1972

Numbers and rates per 1,000 women aged 15–49 years

Year	Hertfordshire residents		England and Wales residents	
	No.	Rate	No.	Rate
1969	967	4.5	49,829	4.4
1970	1,393	6.4	75,962	6.7
1971	1,682	7.6	94,570	8.4
1972	1,933	8.6	108,565	9.9

Table 5 Abortions, Hertfordshire and England and Wales, 1972
Numbers and rates by age groups

Age group	Hertfordshire residents		England and Wales residents	
	No.	Rate	No.	Rate
Under 19	450	13.8	24,590	14.8
20–34	1,068	11.3	63,780	13.0
35–44	360	5.8	17,832	6.3
45 and over	11	0.33	474	0.31
Age not stated	44		1,889	

Table 6 Infant mortality—Deaths from stated causes at various ages under one year of age

Cause of death	Under 4 weeks	4 weeks and under 12 months	Total deaths under 1 year
Enteritis and other diarrhoeal diseases	—	2	2
Heart disease	—	3	3
Pneumonia	4	11	15
Other diseases of respiratory system	—	9	9
Intestinal obstruction and hernia	5	2	7
Congenital anomalies	32	11	43
Birth injury, difficult labour, etc.	52	1	53
Other causes of perinatal mortality	24	—	24
All other external causes	6	18	24
Totals	123	57	180

AGE GROUP																							
Under 4 weeks		4 weeks-1 year		1 -		5 -		15 -		25 -		35 -		45 -		55 -		65 -		75 and over		Totals	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
—	—	—	—	—	—	—	—	—	—	—	—	2	1	1	1	8	9	12	12	12	56	35	79
—	—	—	—	—	—	—	—	—	—	—	—	40	5	14	14	287	61	375	219	355	508	1,209	810
—	—	—	2	—	—	—	—	—	—	—	—	3	1	4	4	13	10	44	33	87	213	155	268
—	—	—	—	—	—	—	—	—	—	—	—	4	3	9	9	44	47	117	151	228	622	420	834
—	—	—	—	—	—	—	—	—	—	—	—	2	2	10	13	32	13	61	51	67	150	172	227
—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	3	2	3	10	4	11	14	23	26
3	1	6	5	—	—	—	—	—	—	—	—	3	5	8	19	34	19	87	59	195	305	349	417
—	—	1	—	—	—	—	—	—	—	—	—	2	—	4	4	43	16	110	24	121	67	291	111
—	—	7	1	—	—	—	—	—	—	—	—	—	—	2	1	3	4	4	4	—	2	10	13
—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	12	6	12	6	24	32	55	52
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	12	2	12	5	5	14	26	22
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	1	3	—
1	4	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4	3	—	14	13	29
—	—	—	—	—	—	—	—	—	—	—	—	1	—	5	3	3	2	9	8	—	2	10	12
—	—	—	—	—	—	—	—	—	—	—	—	1	1	3	3	8	2	6	12	11	29	39	50
—	—	—	—	—	—	—	—	—	—	—	—	2	—	2	2	5	2	2	7	2	2	21	13
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	15	17	—	17	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	7	19	19	19	34	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	7	—	6	3	10
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	2	5	17	11	35
18	14	6	5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	37	29	—
34	18	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	34	19	—
14	10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14	10
1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	32	51
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	88	33
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	77	117
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	30	23
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	15	12
75	48	34	23	16	16	33	17	64	32	68	34	115	101	367	235	847	473	1,277	924	1,511	2,607	4,407	4,510
Totals all causes		Totals all causes																					

Table 8 Death rate from cancers in women

England and Wales

		All cancers		Cancer of breast		Cancer of cervix	
		Nos.	Rate/ 100,000	Nos.	Rate/ 100,000	Nos.	Rate/ 100,000
1961	.	47,188	196·2	9,268	38·9	2,492	10·4
1962	.	47,560	196·9	9,333	38·8	2,499	10·4
1963	.	47,964	197·3	9,424	38·9	2,454	10·1
1964	.	49,235	201·0	9,841	40·4	2,566	10·5
1965	.	49,624	201·3	9,670	39·4	2,442	10·0
1966	.	50,315	202·8	9,803	39·7	2,472	10·0
1967	.	51,267	206·6	10,230	41·2	2,460	9·9
1968	.	52,267	209·4	10,204	40·9	2,434	9·8
1969	.	53,451	213·2	10,622	42·4	2,417	9·6
1970	.	53,840	214·0	10,677	42·4	2,343	9·3
1971	.	54,567	217·4	11,182	44·6	2,315	9·2
1972	.	n/a	n/a	n/a	n/a	n/a	n/a

Hertfordshire

		All cancers		Cancer of breast		Cancer of cervix	
		Nos.	Rate/ 100,000	Nos.	Rate/ 100,000	Nos.	Rate/ 100,000
1961	.	751	174·4	192	44·7	n/a	n/a
1962	.	762	173·0	185	42·0	n/a	n/a
1963	.	743	165·5	169	37·6	n/a	n/a
1964	.	755	164·7	165	36·0	n/a	n/a
1965	.	752	170·8	164	37·2	n/a	n/a
1966	.	765	171·5	163	36·5	n/a	n/a
1967	.	809	179·4	189	41·9	n/a	n/a
1968	.	798	175·6	187	41·2	32	7·0
1969	.	834	181·4	173	37·6	25	5·4
1970	.	878	189·1	184	39·6	22	4·7
1971	.	868	183·3	205	43·3	31	6·5
1972	.	926	193·4	226	47·2	34	7·1

Table 9 Deaths, numbers and rate per 1,000 by age and sex, 1972

Age	Males			Females			Rates both sexes
	Population	Deaths	Rate	Population	Deaths	Rate	
0-4	37,350	125	3·3	35,720	87	2·4	2·9
5-14	83,060	33	0·4	78,580	17	0·2	0·3
15-24	69,280	64	0·9	68,200	32	0·5	0·7
25-34	60,530	68	1·1	60,730	34	0·6	0·8
35-44	61,440	115	1·9	62,330	101	1·6	1·7
45-54	61,790	367	5·9	61,870	235	3·8	4·9
55-64	51,800	847	16·4	52,150	473	9·1	12·7
65-74	25,850	1,277	49·4	34,930	924	26·5	36·2
75-90	10,820	1,511	139·6	24,200	2,607	107·7	117·6

Table 10 Age—Sex distribution of deaths from ischaemic heart disease, 1972

Age	Males		Females	
	No.	Rate/100,000	No.	Rate/100,000
0-14 . . .	—	—	—	—
15-24 . . .	—	—	—	—
25-34 . . .	4	6.6	3	4.9
35-44 . . .	40	65.1	5	8.0
45-54 . . .	148	239.5	14	22.6
55-64 . . .	287	554.1	61	117.0
65-74 . . .	375	1,450.7	219	627.0
75 and over . .	355	3,281.0	508	2,099.2
All ages . . .	1,209	261.7	810	169.2

Table 11 Age—Sex distribution of deaths from lung cancer

Age	Males		Females	
	No.	Rate/100,000	No.	Rate/100,000
0-14 . . .	—	—	—	—
15-24 . . .	—	—	—	—
25-34 . . .	2	3.3	—	—
35-44 . . .	5	8.1	3	4.8
45-54 . . .	40	64.7	15	24.2
55-64 . . .	143	276.1	36	69.0
65-74 . . .	150	580.3	34	97.3
75 and over . .	81	748.6	25	103.3
All ages . . .	421	91.1	113	23.6

Table 12 Accidents

Age	Road accidents injuries	Age	Home accidents injuries
0-4 . .	122	0-4 . .	307
5-14 . .	592	5-14 . .	228
15-59 . .	3,345	15-64 . .	614
60+ . .	353	65+ . .	428
	4,412		1,577

Table 13 Prevalence and control of infectious disease—Notification and deaths

Disease	Number notified	Attack rate per 1,000 population	Deaths
Typhoid	—	—	1
Acute meningitis	11	0·012	6
Dysentery	48	0·051	4
Pneumonia	1	0·001	—
Food poisoning	143	0·152	—
Infective jaundice	157	0·167	—
Malaria	1	0·001	—
Measles	948	1·009	—
Paratyphoid	6	0·006	—
Scarlet fever	129	0·137	—
Tuberculosis :			
(a) Respiratory	103	0·110	12
(b) Other forms	28	0·030	2
Whooping cough	49	0·052	—
Encephalitis:			
(a) Infective	2	0·002	—
(b) Post infective	7	0·007	—
Puerperal Pyrexia	1	0·001	—

Table 14 Prevalence and control of infectious disease—Tuberculosis

Age in years	New cases				Deaths			
	Respiratory		Other forms		Respiratory		Other forms	
	M	F	M	F	M	F	M	F
Under 1	—	1	—	—	—	—	—	—
1	—	1	—	1	—	—	1	—
5	5	—	—	—	—	—	—	—
10	2	3	—	—	—	—	—	—
15	4	—	1	2	—	—	—	—
20	6	4	1	—	—	—	—	—
25	9	5	1	1	—	—	—	—
35	10	8	5	7	—	—	1	—
45	12	4	1	1	1	—	—	—
55	15	4	2	1	4	—	—	—
65	4	2	—	—	2	1	—	—
75 and over	3	1	—	4	3	1	—	—
Totals	70	33	11	17	10	2	2	—

Table 15 Incidence of tuberculosis in Hertfordshire, 1962–1972

Year	Pulmonary tuberculosis		Other form of tuberculosis	
	Numbers	Rate/1,000	Numbers	Rate/1,000
1962	288	0·336	50	0·058
1963	242	0·277	48	0·055
1964	245	0·275	38	0·043
1965	192	0·223	21	0·024
1966	165	0·189	33	0·033
1967	138	0·155	29	0·033
1968	185	0·188	37	0·038
1969	139	0·154	26	0·029
1970	128	0·140	26	0·029
1971	117	0·126	29	0·031
1972	103	0·110	28	0·030

II Personal health services

Reorganization of health services

Dr. Shaw, Divisional Medical Officer, South-West Herts, writes:

“ Apart from senior members of the public health service and those few general practitioners and hospital personnel on Joint Liaison Committees the medical profession knows very little about the details of the reorganization, and what little it does know it regards with deep suspicion. Various bulletins on reorganization have gone only a small way towards clarifying the picture for doctors who have neither the time nor the inclination to read White Papers and various reports connected with the reorganization. It may well be that once the Hertfordshire Area Health Authority is appointed and makes decisions on matters placed before it by the Joint Liaison Committee, that medical and other personnel will understand more clearly the roles they are expected to fill.

Initially, the greatest change will be seen in the public health service. For over one hundred years medical officers of health have been working to make the environment safe and to introduce new and needed services. Their work will still have to be done and it is to be hoped that in their new role as community physicians they will be given the tools to do the job. One of the great advantages of the medical officer of health has been in his daily contact with members sensitive to the needs of the area. It is universally doubted, despite the reassurances of the Secretary of State, that community health councils will have the same influence on overall health services as public health committees have had on local public health problems.”

Dr. Earle, Divisional Medical Officer, East Herts Division, writes:

“ This year was a springboard for the future. The medical and nursing staff did not know how they were to be reorganized. However, we were sure that a similar force would be dealing with similar problems in a similar population after reorganization. We shall be an effective force if our professional skills are excellent, if our personal relationships are sound, if our premises are satisfactory and if our morale is good. The underlying strategy of the past year has been to promote these points.

At present the National Health Service employs near 1,000,000 people and spends approximately 5 per cent of the gross national product. There is a strong case for trying to improve the organization of such a large work force. However, this means change and I think it is worth remembering what Machiavelli wrote about change some four hundred years ago. Even when smallpox and plague were common causes of death he maintained that change was both difficult and dangerous. I have no doubt that he was right.

Recently I have been approached by senior local government officers who are finding themselves grossly overworked by the processes of their reorganization. No one is immune from overwork, the stresses of uncertainty and diseases due to stress. It worries me that the occupational health of staff has been considered so little in the reorganization of the National Health Service and local government.

There appears to be two distinct views about the future of the National Health Service with reference to local government. The medical view is that doctors will need to be consulted, possibly more widely than at present. No district has, however, consulted me about any aspects of reorganization concerned with environmental health or communicable disease. Only one district has consulted me about personnel problems.”

Co-ordination with hospital and family doctor services

Dr. Shaw, Divisional Medical Officer, South-West Herts, writes:

“ Co-ordination between the county council services and the hospital and family doctor services is already at a high level. This is the fortunate result of the divisional medical officer being also medical officer of health for the division which he serves so that the public health services as a whole can act rapidly in providing expertise and asking for it in return from the other two branches of the service. Nothing has done more to bring together the general medical and public health services than the attachment scheme. There is now 100 per cent attachment of health visitors, home nurses and midwives to general practice and as a general rule the services are used well and wisely. Over the past 5 years also there has been an increasing rapprochement between the hospital and the public health services in that domiciliary midwives are delivering the babies of their patients in Shrodells Maternity Wing to an increasing extent, nursing officers act as liaison with the paediatric and geriatric services, home nurses are seeing an increasing number of early discharges of hospital patients and a close co-operation exists between the hospital social workers and local authority services.

It is hoped that as a result of the reorganization the contact between hospital and community will improve further and expand the horizons of hospital personnel who are not at present fully aware of the potential community-based health services.”

Dr. Earle, Divisional Medical Officer, East Herts, writes:

“ Co-ordination with hospitals takes place in several linked ways. Health visitors attend hospital paediatric clinics, by rota. A paediatrician attends an assessment centre at a Hoddesdon clinic monthly. A medical officer in department attends a hospital assessment centre at Bishop's Stortford. The health visitors concerned frequently attend these clinics with their patients. A health visitor or nursing officer attends periodically at a geriatric unit before old people are discharged.

G.P. liaison: All health visitors are attached to general practitioners. It is a sound arrangement, though it can produce divided loyalties in health visitors. The initial introduction is extremely important, so that all concerned really understand their roles in health care. We were three and sometimes more health visitors short of establishment during the year.

The local general practitioners have an informal club that meets about 10 times per year. The divisional medical officer frequently attends. It has been a useful forum for the exchange of views on reorganization, as well as clinical medicine.”

Dr. Norman-Taylor, Divisional Medical Officer, St. Albans Division, writes:

“ The attachment of health visitors, district nurses and midwives to general practitioners has now been fully operating for several years, and there seems to be excellent collaboration between the two services. General practitioners are, for the most part, now well aware of the rôles of these ancillary helpers. The value of health visitors as a link with the social workers, housing department, and other related services, is now fully appreciated. Collaboration with hospitals, and particularly with hospital social workers, is also developing well. In the case of geriatrics this has now been smoothly running for some time, and our staff make regular weekly visits to wards to discuss the needs of patients about to be discharged. It was hoped that we would be able to attach a special health visitor to the paediatric department at the City Hospital, but this has not yet been possible owing to shortage of staff. Our maternity services are now virtually 100 per cent in hospital, with most of the 48-hour cases being conducted

by our own midwives. Plans for the general practitioners themselves to undertake their own cases in hospital, however, have been delayed owing to lack of suitable accommodation.”

Health centres

The health centre building programme has not made quite the progress expected largely due to the problem of acquiring suitable sites and other difficulties over which the county council has no control.

No new centres were opened in 1972 but the building of four centres at Cuffley, Royston, Stevenage (St. Nicholas area) and Standon has commenced and is expected to be completed towards the end of 1973 or by the Spring of 1974. Plans are also well advanced for the centre at Harpenden.

The interest of family doctors in practising at health centres continues to grow and the future programme provides for centres in the following areas:—

Berkhamsted	Rickmansworth
Bushey	St. Albans—Central
Flamstead End, Cheshunt	St. Albans, How Wood
Hemel Hempstead, Apsley End	Sandridge
Hemel Hempstead—Bennetts End	South Watford
Hertford	Stevenage—East of Broadwater
Letchworth—Jackman's Estate	Stevenage—Symonds Green
Markyate	Waltham Cross
Much Hadham	Ware
Old Stevenage	Watford—Central
Radlett	Watford—North
Redbourn	Welwyn Garden City—Panshanger

Nursing services

Miss King, Director of Nursing Services, reports.

In April, 1972, the new nursing management structure (Mayston) as recommended by the Department of Health became operative. This meant that there was an increase of 10 nursing officers in the lower middle management category. The total number of officers is now 25 and in addition 2 community nurse tutors. With these extra officers, opportunity has been given to look closely at the nursing service, and to set in motion schemes for the improvement of the standard of the service generally.

With the reorganization of the health service in 1974 and proposed accent on domiciliary services, it was fortunate that some time was to be in hand with extra staff to assist in the preparation of improved nursing services to meet the demands of the future.

Nursing officers have attended management courses.

Links with hospitals

During the year, meetings have taken place at all levels between domiciliary and hospital nurses. This move towards integration has given greater understanding of each other's work, and a gradual improvement has been observed in the continuity of the care of patients from home to hospital and vice versa.

Members of the hospitals' teaching staff have given assistance by lecturing to nurses on some of the training courses, and the domiciliary teaching and nursing officers have reciprocated by lecturing to hospital nurse students.

Some hospital out-patient departments have health visitors in attendance. These are mainly in the geriatric, paediatric, maternity and venereology clinics. This practice, it is felt, gives a better service to the patients, and the follow up in the patient's home is given with more knowledge, positive advice and assistance.

Midwifery service

Births

Although the number of births declined by over 600 during 1972 compared with 1971, the number of women confined in hospital continued to increase (Table 22). In 1972 there were 11,817 births notified to the county medical officer as taking place in hospital as against 1,756 deliveries at home, making a total of 12·9 per cent domiciliary confinements. The highest domiciliary rates were again in Hertford, Hoddesdon, Ware Rural and Letchworth where rates exceeded 20 per cent compared with rates less than 5 per cent in some other parts of the county, i.e. Baldock, Royston, Potters Bar, Elstree and Bushey.

In 1972, 1,635 women were discharged from hospital within 48 hours of delivery and another 7,846 before the tenth day of the puerperium. This meant that 9,481 women of the 11,817, i.e. 80 per cent, delivered in hospital received some post-natal care from the domiciliary midwife.

Maternal mortality

There were no maternal deaths in the county during the year.

Notification of intention to practice

During the year 473 midwives notified their intention to practice in the county, 304 of whom were in the hospital service. Of these 304, 57 were employed through private agencies.

Midwifery refresher courses

To enable all midwives to be up to date in the care of the ante-natal patient, annual courses of a 3-day duration have been arranged. These particular seminars have been directed specifically to learning about ante-natal exercises, methods of relaxation and teaching materials. In the year, 32 midwives attended these.

Additionally, a further 35 midwives attended a series of 5 lectures related to their work.

In accordance with the rules of the Central Midwives Board, 26 midwives attended refresher courses of one week's duration in centres outside the county.

Student midwives

There were 44 midwives who were approved as teaching midwives by the Central Midwives Board. These midwives have assisted in the domiciliary training of 135 students from 7 hospitals, 4 of which were within the county boundary. 36 of the 135 students were from Watford General Hospital (Shrodells Maternity Wing).

Student midwives' training has broadened, and during their domiciliary period of training arrangements have had to be made for them to appreciate other health workers and the Social Services department.

Ante-natal instruction

All the domiciliary midwives have been trained in methods of teaching relaxation exercises and in preparing expectant mothers for their confinements. During the year 2,007 patients who were booked for hospital and 204 booked for home delivery made a total of 10,127 attendances at classes organized by the domiciliary midwives.

Phenylketonuria

All domiciliary midwives carry out the Guthrie test on babies at about the seventh day after birth, and in this county all their blood test cards are sent to Great Ormond Street Hospital.

In 1972, 4,064 babies were tested by the midwives, and in 603 of these cases repeat tests were made. No positives were found.

Integration of midwives—domiciliary and hospital

The decrease in the number of births and domiciliary confinements has necessitated consideration being given to domiciliary midwives, besides maintaining the service, also retaining their skills. For these reasons the practice whereby the domiciliary midwives go into hospital to deliver patients booked in the main for early discharge has increased. In 1972 these midwives delivered 315 women in hospitals. There are 9 hospitals in Hertfordshire which have maternity beds, and arrangements for domiciliary midwives to work in the hospitals have been agreed as a principle with them all, but at the end of the year in only 4 of these was there an active arrangement. The reasons for non-function were either due to distances, busy domiciliary practices, or temporary inconvenience on the part of the hospital or domiciliary arrangements.

Home nursing

The home nursing of patients has continued to increase. As will be seen in Table 24, 18,264 patients were visited as compared with 16,022 in 1971, an increase of 14 per cent. Patients over the age of 65 years amounted to 54·2 per cent.

Many general medical practitioners now have regular treatment sessions at which the home nurse is in attendance. Nurses have attended and treated 58,985 patients at these sessions. Additionally, the nursing staff have assisted the doctors at cytology sessions and other screening clinics (Table 25).

539 state registered nurses, enrolled nurses and auxiliaries are engaged in the service (Table 21—Staff).

Night nursing

The state enrolled nurses employed carry out night nursing duties as and when necessary. In the year, 32 patients received nursing care for a total of 77 nights. In addition, 7 patients received night nursing through the Marie Curie Foundation Fund, which is administered on behalf of the Foundation through the Director of Nursing Services.

District nurse training and in-service training

The teaching section of the nursing service continued to expand in 1972.

District nurse training

Three courses for state registered nurses and two for state enrolled nurses were arranged to prepare them for the National Examination in District Nursing, and during the year 44 S.R.Ns. and 22 S.E.Ns. were successful in the examination (2 of the S.R.Ns. passed at the second attempt). A limited number of nurses on each course were accepted for training from Luton and Bedfordshire.

The integrated S.E.N./D.N. training arrangement with Abbots Langley Hospital resulted in 4 nurses obtaining the National Certificate, 2 of these being successful at their second attempt.

Hospital student nurses

(a) Community care option

The work involved in implementing the General Nursing Council's syllabi for student nurses undertaking general or psychiatric nurse training has increased steadily. In 1972, 22 students from the West Herts, Lister and Mid

Herts Schools of Nursing undertook a 10-week period of community care training. Each student spent 7 weeks with home nurses, midwives or health visitors and 3 weeks in study blocks. The study blocks were taken concurrently with the state registered nurses taking the district nurse training course.

(b) Geriatric and obstetric option

There were 123 student nurses from psychiatric and mental subnormality hospitals who spent a period of 2 weeks with nurses and health visitors for community experience. It has been recommended that this period of time be extended in 1974.

Other courses

Psychiatric community nursing

During the latter part of 1972 saw the appointment of the first psychiatric community nurse, and a special induction course of 10 weeks' duration was organized, which included part of the district nurse training course.

Practical work instructors' course

This was of 2 weeks duration, designed for nurses assisting in giving practical experience to student nurses.

State registered nurses (assistants to health visitors) and auxiliary helpers also attended courses specially arranged for their needs.

Accommodation

Difficulties have been experienced in regard to accommodation for the training courses. The shared accommodation at Trevelyan House, Welwyn Garden City, with the health education section, has proved to be inadequate. This has meant that the Civic Centre, Welwyn, has had to be hired for the examinations, and for lectures where more than 18 are to be in attendance.

The Nurse Training School at Queen Elizabeth II Hospital has been very helpful in providing classroom facilities, and the co-operation of the teaching staff has been appreciated.

In-service training

The yearly series of lectures for all grades of nursing staff were held in the autumn. Some of the topics included were haemodialysis, care of the dying, and research in nursing.

The seminars on mental health over a period of some 15–20 weeks for health visitors and nurses were continued at Napsbury Hospital. Two of these periods for each of the two grades of staff were organized.

The Family Planning Association arranged a 2-day appreciation course at which some 40 nurses were in attendance.

Two nurses completed the full family planning course, and are assisting the general medical practitioners to whose practice they are attached.

Nursing homes

At the end of the year there were 10 registered nursing homes which received medical, surgical and chronic sick patients. The total number of beds available was 228. One home of 30 beds is approved by the Department of Health to take patients for abortions.

Each nursing home was visited at regular intervals by a nursing officer.

Health visiting

The main work of the health visitor is concerned with the home visitation of children under the age of 5 years, and in the year this accounted for 72 per cent of their work whereas in 1971 it was 73·4 per cent, in 1970 74·1 per cent, and in 1969 78·5 per cent. This slow decline was offset perhaps by the increase in children's sessions held in general practitioners' surgeries—1,759 in 1972 and 1,517 in 1971. More children were also asked to attend clinics for the purpose of carrying out developmental tests by health visitors and doctors in department. Of the total 89,370 first visits made by health visitors during the year, 2,174 were at the special request of hospital personnel and 6,891 at the general practitioners' request.

Nursery and Child Minders' Act

The health visitors continued to inspect and supervise the child minding facilities in the county on behalf of the Social Services Department, and during 1972 3,335 visits were made.

Health education

Group health education sessions conducted by the health visitors during the year totalled 1,970, as compared with 1,127 in 1971. These sessions were held not only at health centres and clinics, but also in hospitals and general practitioners' surgeries.

In addition sessions took place in the schools.

Tuberculosis

There were 3·5 health visitors engaged entirely on work with tubercular and other patients with chest diseases. In addition there were 2 health visitors who also worked in the chest clinic and followed up patients as required, in addition to other health visiting duties. In the year, 1,315 home first visits were made, and 2,251 visits made to contacts of tuberculars. Overall there was a 0·4 per cent decrease in home visits in 1972 as compared with the year 1971.

Venereal disease

There were 5 health visitors who as part of their duties attended the venereology clinics, trace and follow up contacts. In 1972, 325 clinics were attended, and 129 visits made to 91 contacts, or patients.

Health visitor students

In 1972, 25 health visitor students completed their training, and a further 17 commenced training; in addition, 7 were accepted for the extended course at Stevenage College. This course is on a part-time basis extending over a period of 2 years and 3 months.

There were 27 qualified field work instructors who had a reduced case load and assisted with the practical training of these students.

Congenital abnormalities

The notification of congenital abnormalities which was started in 1963 continued throughout the year. There were 280 children notified with 303 abnormalities. The rate of congenital abnormalities per 1,000 live and still births was 20·6 and higher than the rate in 1971 (15·7).

Welfare foods

As in previous years, the bulk of welfare foods was sold by voluntary workers and by shopkeepers. I am very grateful to all those people for their services.

The welfare foods currently available are:—

National dried milk (20p)
Children's vitamin drops (5p)
Vitamin A, C, and D tablets (6p)

Development screening

Developmental screening of pre-school children is being increasingly developed throughout the county. The aim is to minimize the effect of handicapping conditions by early ascertainment of the handicap in order that the medical, educational, and social treatment of the child can be planned in co-operation with the parents to minimize so far as is possible the effect of the handicap.

To further this policy increasing numbers of medical officers and health visitors have received training in the techniques of developmental assessment. In the spring a series of nine lectures and demonstrations given by experts pre-eminent in this field of paediatrics, was held for medical officers in department.

Dr. Norman-Taylor, Divisional Medical Officer, St. Albans division, writes:

“ The most marked feature of the past year has been the clarification of the organizational basis of our arrangements for developmental paediatrics. We now have two members of staff who have taken specialized courses on this subject. One of these is Dr. Joyce Leveson, who, during the year, was appointed Senior Clinical Medical Officer. It is largely thanks to her that this aspect of our work is now firmly established. The links with the hospital paediatricians, one from Barnet General and the other from St. Albans City, have been put on a sound footing, and the lines of our respective responsibilities clearly drawn. The stated objective, namely to ensure that every child is duly screened at the appropriate developmental epochs, is working well, though administrative oversight is sometimes difficult when this is done by general practitioners.”

Dr. B. E. Powe, Senior Clinical Medical Officer, Mid Herts division, reports:

Child health assessment unit

This unit was started in April, 1972, following the appointment of a senior clinical medical officer with special responsibilities for children under five years of age, and in October, 1972, the assessment team was joined by the paediatrician to the Queen Elizabeth II and Lister Hospitals.

The present team consists of:—

Dr. A. Shurz—Paediatrician
Dr. B. E. Powe—Senior Clinical Medical Officer
Mrs. D. Randall—Speech Therapist
Miss J. Robson—Nursing Officer

who work in close collaboration with:—

Dr. J. Anderson—Child Psychiatrist
Mrs M. A. Gregory } Educational Psychologists
Mrs. A. M. Smith }

The assessment unit is held weekly at Gooseacre Health Centre, Welwyn Garden City, and monthly at the Queensway Health Centre, Hatfield, and members of the team see children at home or in a nursery unit as necessary.

Children may be referred to the unit by the paediatrician, general practitioner or medical officer in the Department of Health.

Table 16 Source of referral to the assessment unit

Paediatrician	10
General practitioner	2
Medical officer	13
(in Department of Health)	
Speech therapist to the unit	3
	<hr/>
	28
	<hr/>

Health visitors, speech therapists, or social workers may often be the first to recognize the child with a handicap through their close work with children and parents, and by drawing the attention of the medical practitioner to the problem play an important role in procuring a full assessment of the child and his needs.

Since starting the unit in 1972, 28 children have been referred for full assessment, the majority of the children suffering from severe handicapping conditions.

Table 17 Diagnosis of type of case referred

Spina bifida	2	Cerebral gigantism (Soto's syndrome)	1
Encephalocele	1	Hunter's syndrome	1
Microcephaly	1	(Mucopolysaccharidosis II)	
Skeletal defects	1	Dystrophia myotonica	1
(Freeman-Sheldon syndrome)		Hypsarhythmia	1
Congenital heart	2	Severe dysphasia	1
Hypothyroidism	1	Speech and language difficulties	5
Tuberosc sclerosis	1	Retardation of unknown aetiology	2
Choreo-athetosis	1	Battered baby syndrome	1
High blood lead level	1	Behaviour problem	1
Severe mental retardation and growth failure	1	Educational difficulties	2
		Cortical blindness	1

Amongst the 28 children there were 79 major handicaps, with a possible further 14 still not fully assessed, showing the high incidence of multiple handicaps among these children.

Table 18

Type of handicap	Total number of children seen	Number with handicap	Number with possible handicap	Percentage incidence of handicap
Delayed language development	28	22		79
Articulation defect	28	3		11
Mental retardation	28	14	(8)	50+
Motor delay below level of General Quotient	28	11		39
Manipulative difficulty below level of General Quotient	28	3		11
Visual defect	28	11		39
Hearing defect	28	3	(6)	11+
Hyperkinetic behaviour	28	6		21
Fits	28	6		21
Total	28	79	(14)	

79 per cent of the children were suffering from delayed language development equal to or greater than 2 standard deviations below the norm, on the Reynell Language Scale, which is supportive evidence of the need to have a speech therapist as a member of the team both in assessment and in planning a language programme for these children.

Over 50 per cent of the children were probably mentally retarded.

Table 19

Developmental level expressed as a percentage of the norm	Number of children seen	Assessment by developmental General Quotient	Assessment by Intelligence Quotient	Percentage of number seen	Total
0-50 . .	29	7 (+4)	—		7 (+4)
51-75 . .	29	7 (+4)	—		7 (+4)
76-100 . .	29	1 (+3)	1		2 (+3)
101-120 . .	29	0 (+1)	—		0 (+1)
121-140 . .	29	—	1		1

The majority of these children were so handicapped that it was not possible to obtain an accurate figure for intellectual ability, but the General Quotient on the Ruth Griffiths Mental Development Scale was taken as a guide to their present level of functioning; in some of the children an accurate figure for a General Quotient was not obtained due to a wide scatter of results making the results unreliable, or due to hyperkinetic behaviour on the part of the child making formal testing impossible. In these cases the probable level of ability was estimated from overall observations by the team and the number included in brackets in Table 19.

In two of the more able children accurate assessment of intellectual ability was carried out by the educational psychologist and many of the children seen may have assessment of educational needs when recommended by the psychologist.

The aims of the child health assessment unit should be based on an interdisciplinary (rather than multidisciplinary) approach to the handicapped child, and since starting the unit in 1972 there has been very close collaboration between the hospital paediatrician, therapists, nurses and staff in the Health and Social Services Departments. The child health assessment unit is not only responsible for diagnosis and assessment of needs, but also responsible for helping to meet the needs of children and the families of the handicapped child, by counselling, group work with parents, combining with therapists and teachers in planning programmes suitable for the developmental level of the child and his disability in order to develop his potential to the full and to advise on medical and nursing care.

At present there is a lack of unification of services for the very young handicapped child and his family with limited nursery facilities for meeting the needs of the individual. Suggestions have been put forward for a nursery unit for handicapped children where health, social services and education departments can combine to meet this need.

Immunization and vaccination

Immunization—whooping cough, diphtheria, tetanus, poliomyelitis

The immunization rates for the county are generally good, although there is considerable variation from one county district to another. For children aged 2-3 in 1972 (the age when children should have completed their primary courses of immunization) 83.7 per cent of children were protected against diphtheria and tetanus, 81.5 per cent against whooping cough, and 84 per cent against poliomyelitis.

Measles vaccination

Before measles vaccination, epidemics of measles occurred every other year with large numbers of cases of measles with a toll of complications and the occasional death. In the epidemic year many of the children under the age of 5 or 6 years who had not previously had measles contracted the disease. This led to a high number of immune children in the population and in the following year there were not sufficient children to support an epidemic. However, by the second year sufficient non-immunes had accumulated to support an epidemic. Measles vaccination has broken this epidemic pattern by increasing the number of immune children in the population and preventing the occurrence of the normal 2-year outbreaks. The percentage of 2–3-year-olds in 1972 who had been vaccinated by the end of 1972 showed a small rise to 68·6 per cent compared with 65 per cent in the similar age group at the end of 1971. It is probable that this level of vaccination is not high enough, and a sufficient number of non-immunes will accumulate over a period of time and localized outbreaks will still occur but at less frequent intervals than in the past.

German measles

The programme of vaccinating 13-year-old girls against german measles continued in 1972 with 4,438 children being vaccinated. The county council adopted the scheme for the rubella vaccination of women in “at risk” groups (DHSS Circular 17/72—“Vaccination against Rubella for Women of Child Bearing Age”). In this scheme women of reproductive age who come into contact with large numbers of children in their jobs—school teachers, nursery nurses, nurses, etc.—can be offered vaccination against german measles. The women are given a blood test first to ensure that they are not already immune to the disease. Because of the problems created to the public health laboratory service by testing potentially large numbers of blood specimens, South-West division and St. Albans division were selected to carry out pilot trials of the scheme in 1972.

Battered babies

From the administrative point of view efforts were concentrated during the year on improving communications between staff and departments and in bringing to the attention of health workers and others the importance and reality of this condition.

Considerable emphasis was laid on it in the nurses' in-service training programme, and a series of highly successful seminars was organized by divisional medical officers. In addition to the staff of the health department, social workers, general practitioners, hospital medical and nursing staff, educational psychologists, police and members of interested voluntary organizations attended. The seminars were recognized as training sessions for general practitioners. It is pleasing to note that the attendances at these seminars was very good, reaching 200 at some of the seminars. Dr. J. M. Cameron, M.D., Ph.D., Reader in Forensic Medicine at the London Hospital Medical College, and his colleague Mr. B. G. Sims, B.D.S., Lecturer in Forensic Odontology at the London Hospital Medical College, were the principal speakers and I am indebted to them for their invaluable assistance in making these seminars so successful.

The Liaison Committee on battered babies met on two occasions. Following consideration of the letter from the chief medical officer on this subject one of the consultant child psychiatrists and a consultant responsible for casualty services were asked to join the committee.

Considerable discussion centred on improving the awareness and knowledge of field workers and it was as a result of a recommendation of the Liaison Committee that the seminars mentioned earlier in this report were arranged.

It was also thought that it would be helpful in alerting family doctors if casualty departments would inform them of the attendance of injured children

under the age of 2 years. This would ensure that the doctor and health visitor would at least be aware of those children on his list who suffered injuries requiring treatment but who had not been brought to the surgery. Discussions were initiated with officers of the Regional Hospital Board to see if such a scheme were feasible.

Another major step forward was the establishment of an understanding with Dr. Cameron, Reader in Forensic Medicine at the London Hospital Medical College, and his colleagues that they would be willing to give further advice to doctors where the diagnosis of this condition was in doubt.

To clarify roles in dealing with suspected cases it was agreed that the divisional social services officer would act as co-ordinator and that the Social Services Department would have the responsibility of deciding if and when to inform the police of any case. It is pleasing to record the improving relationship with the police in this area of work.

During the year 14 children considered to have been "battered" were referred to the Social Services Department from various sources in the county. This is an increase of six over 1971. There is no reason to suppose that there is a real increase in the incidence of this condition, but rather that as a result of field staff being much more aware of the possibility, we are getting nearer the true incidence.

"Well woman" clinics

This scheme has been in operation in the county since September, 1965, and clinics were held in all the larger towns. These "Well Woman" clinics offered screening tests to exclude precancerous conditions of the cervix to all parous women mainly between 35-60 years. The women doctors in charge of the clinics also carry out a breast examination and arrange for the urine to be tested for any abnormal constituents. Not infrequently gynaecological abnormalities are discovered on examination and in these circumstances the clinic doctors refer the patient to the family doctor for treatment. Women attend either by directly seeking an appointment or are referred by the family doctors.

Although the majority of the clinics were held during the day, some were evening clinics, and in addition teams visited some of the larger factories or industrial concerns employing women workers. A domiciliary service is provided where the situation demands it, i.e. if women are unable to attend a local clinic either for domestic or other reasons specially trained midwives visit the home and carry out the test. Cervical smears are also taken by family doctors and at the family planning clinics.

Cervical cytology

Dr. Earle, Divisional Medical Officer, East Herts, writes:

"There is a recall of those who have attended by routine methods and clinic publicity. Health visitors and the nursing staff encourage patients to attend. It is worth noting that in the whole county only 46 women died under the age of 75 with cancer of the uterus. If one estimates the usual expectation of life as 75 years, the total life loss in this group was 810 woman years. These deaths represent less than 3 per cent of all female deaths aged 25-75. Some of these cancer of the uterus deaths are due to cancer of the body of the uterus and are not preventable. By contrast, a total of 4,400 man years of life are lost due to road traffic accidents (both sexes) in the county. This is not a plea for less cytology, but for greater emphasis on road safety."

Family planning

Mention was made in my report for 1971 of the rapid growth in approved grants to the four voluntary organizations providing family planning services in Hertfordshire. There had been an increase from £2,000 in 1969–70 to £27,500 in 1972–73 and this latter figure was a half-way stage to the full implementation of a free consultation and advice service to all, plus a free supply service to those mothers needing family planning on medical or social grounds. In the autumn of 1972 the Health Committee recommended that the grant for the next financial year should be raised to £85,000 and this sum was approved by the Finance Committee and county council. This enlightened outlook was greatly appreciated by the voluntary organizations and also by the Conservation Society which had made representations to the county council for a free family planning service for males and females and for greater publicity for the services available.

The county council have also approved a domiciliary service for the North Herts division and discussions have been held with the Family Planning Association on how best this service could be provided. At the time of writing this report, however, it would seem that the demand for such a domiciliary service is very slow in developing.

Tuberculosis

The incidence of tuberculosis continued to fall in 1972, with only 131 new cases compared with 146 in 1971. The B.C.G. vaccination programme continued during the year, when 17,962 children received B.C.G. vaccination.

I am grateful to the chest physicians for the reports of their work in the prevention and treatment of tuberculosis and other chest diseases during 1972.

Report of Doctor J. H. Angel, Hemel Hempstead Clinic, Dacorum Division:

“ There has been an increase in the number of new patients referred to the clinic and the number of new notifications of tuberculosis has risen from 9 in 1971 to 17 in 1972.

It would appear that tuberculosis is still a force to be reckoned with.”

Report of Doctor A. G. Hounslow, Barnet Clinic, Elstree Rural District, part of Hatfield Rural District and the London Borough of Barnet:—

“ The catchment area of the clinic is only partly in Hertfordshire, population served 60,000, with the rest of the population served in the London Borough of Barnet, population 170,000. The total volume of work at the clinic remains much as in the past 5 years, with a tendency to slightly more tuberculosis work in the new attendances. Overall, tuberculosis and non-tuberculosis work remains evenly balanced, though on the whole non-tuberculosis patients tend to be more time-consuming and to present more difficult clinical problems.

There were 53 new cases of tuberculosis notified to the clinic in 1972, and these cases have risen steadily over the last 4 years—clearly no cause for complacency. Of these cases, 53·5 per cent were in immigrants. There was, however, only 1 new case from the Hertfordshire area, and this was an all-time low. This low incidence from Hertfordshire is presumably linked to some extent to immigration, as there is no significant number of immigrants in Boreham Wood and Brookmans Park, but even so in the Borough of Barnet where the immigrant cases occur the number of newly-notified British citizens also remains high.

It is very disappointing to note that the number of new cases of cancer seen at the clinic have shown a further rise on the high figure of 1971, and the 78 cases seen in 1972 were more than double the 37 cases seen in 1969.”

Report of Doctor N. Macdonald, Hitchin Clinic, North Herts Division:

“ New notifications for 1972 totalled 17 as against 30 in 1971; only 8 were sputum-positive; 5 were immigrants. Bronchial carcinomas totalled 52, unchanged compared with 1971. 781 new patients were seen as compared with 891 in 1971. X-ray only patients totalled 520 (537 in 1971). Total attendances were 6,643. The general picture remains much the same as in previous years with the number of notifications of tuberculosis even lower than before. Relatively speaking, it is higher in the small immigrant community than in the British born population. Asthma remains the commonest condition dealt with and though difficult to treat, responds reasonably well to the variety of new drugs now available. Smoking is still too prevalent in the public as a whole but patients are now more easily persuaded to give it up.”

Report of Doctor Rhys Jones, Cheshunt Clinic, East Herts Division:

“ The figures for tuberculosis seen at this clinic remain small.

Most chest clinics are fully integrated with the hospital service and to many people, including those in the medical and nursing professions, they may now appear indistinguishable from ordinary medical out-patient departments. The very word ‘ clinic ’ has lost its precise meaning, but one should be reminded that the work in a true clinic involves preventive medicine. How far can the techniques developed in tuberculosis clinics be applied to patients with other chest diseases, who now outnumber those with tuberculosis?

There is no doubt that in asthma the clinic approach is of great value, but it is questionable in chronic bronchitis, yet the causes of this disease are understood and preventive measures have been shown to succeed. There are several reasons which explain this paradox. One is the time lag extending over several decades between the start of the disease and the development of serious disability. Many patients ignore early symptoms such as cough and sputum, and only become seriously worried when breathlessness develops. There is a tendency, therefore, for both patients and doctors to be concerned with only the advanced state of the disease. A technique such as the serial X-ray, so valuable in tuberculosis, might even be counterproductive in that an assurance to a chronic bronchitic that his X-ray shows no change, may only confirm his view that he need take no further action, and experience has shown that routine X-rays taken at intervals as short as six months are of little practical value in picking up early cases of cancer in bronchitics or heavy smokers. However, at whatever stage one meets the disease, there is the need for preventive action to avoid further deterioration or the development of complications. Indeed, this is the only practical approach to the management of the condition. The patient has to learn how his disease has been caused, how to manage it on a day-to-day basis, grasp the purpose and value of any treatment and, equally important, he must learn to change his habits, accept the limitations of treatment and cope with any disability.

This education of the bronchitic, to be successful, depends heavily on his previous knowledge and attitude to matters of health in general and so, to a considerable extent, this reflects on the general standard of health education. It is clear that there are still many basic lessons to be learned by the public in this country. One is that health is not a consumer product to be held by right, and to be bargained for when it is lost. One needs only to view the scene on any Sunday morning on any housing estate, when the ritual of cleaning the family car begins. The owners will be enjoying their first cigarettes of the day. While they are polishing, oiling and otherwise coddling their cars, which in any case can be discarded and replaced when worn out, they are at the same time steadily destroying the delicate structures of their lungs, which are irreplaceable and have to last a lifetime. The irony of this situation passes them by.irate owners have been known to deposit their ‘ rogue ’ cars outside the makers’ factories demanding redress. Sadly one must report that there are patients who behave

like this in the doctor's surgery in regard to their lungs. Unfortunately, these tactics cannot possibly work, even if they were to be directed at the right target. Sit-ins by chronic bronchitics in cigarette factories could not improve their lot! When confronted by such attitudes, it can be realized that health education is a formidable task requiring fortitude from the physician and his staff."

Report of Doctor P. W. Roe, Watford Clinic, South West Herts Division:

"In 1972 new notifications of tuberculosis were: respiratory 44 cases; non-respiratory 11 cases; total 55 cases, 9 more than in 1971. This is the highest figure since 1969 (61) and the same number of cases as was notified in 1965, the first full year after the Regional Hospital Board appointed a second consultant to the department, only to abolish this post in 1971, on the grounds of diminution in the amount of work. 9 of the new cases were members of an immigrant community or 16 per cent of the total number of newly notified cases, compared with 35 per cent in 1971. There is therefore a sharp drop in the number of new cases found among immigrants.

The number of persons under regular supervision for tuberculosis has fallen slightly to 1,884. The number of new patients from whom tubercle bacilli have been isolated, has increased to 27, the highest figure since 1969 and 7 more than were found in 1965.

The allergy clinic, started in 1968, has been extended and many new patients have been referred during the year, from a wide area. In June, 1972, a smokers' advisory clinic was started and it is hoped that this will prove to be a useful service to those wishing to abandon the dangerous practice (from a health standpoint) of smoking tobacco, and who are unable to stop smoking without assistance."

Report of Dr. T. A. W. Edwards, St. Albans and Queen Elizabeth II Chest Clinics, Mid Herts Area:

"Only 11 new cases of pulmonary tuberculosis were found in 1972. Two had a positive sputum on direct examination, one was positive on culture; the others were negative. In addition, 4 cases of tuberculosis glands of neck in immigrants from Asia and one tuberculous kidney in an Englishwoman were found. The number of new cases of pulmonary tuberculosis is the lowest we have ever had and does represent a continuing trend in a downward direction.

We received information in the latter part of the year that a student at a college in the county had been found on returning home to the north of England to have infectious pulmonary tuberculosis. A fellow student had an haemoptysis soon after this and was found to have a primary tuberculous infection and probably bronchiectasis. He received treatment and has now returned to Swaziland. 197 contacts were tuberculin tested. 139 gave a positive reaction and of these 111 had had B.C.G. All positive reactors were X-rayed but no further cases of tuberculosis have arisen. In addition a considerable number of day release students were sent mass X-ray forms but no new cases have been found. In addition, 44 members of staff, who were not tuberculin tested, were X-rayed with negative results.

This large-scale examination of contacts is very time-consuming and the yield has in fact been nil—the one case discovered being found as a result of having a haemoptysis. However, in a closed community where the source case has had a sputum positive on a direct smear, and infectivity would be high, it is difficult not to proceed with the complete investigation of all possible contacts.

As usual, asthma, chronic bronchitis, and lung cancer, provide the bulk of the work in the clinic, and these take up much more time in investigation and management than tuberculosis. The total number of attendances at a clinic from year to year is not, therefore, necessarily a reliable guide to the amount of work done."

Venereal diseases

The venereal diseases are not notifiable but venereal disease clinics make returns on the numbers of people attending clinics during the year. A total of 2,839 patients attended the venereal diseases clinics in Hertfordshire in 1972 (2,581 in 1971), approximately 80 per cent of these being Hertfordshire residents. A number of Hertfordshire residents are treated at clinics outside the county. Some clinics out of the county do not make returns to the county health department and the figures given for 1972 are based on all patients attending Hertfordshire clinics on the assumption that the number of out of county residents treated in Hertfordshire is approximately balanced by the number of Hertfordshire residents treated outside the county.

There were 11 new cases of early syphilis treated at Hertfordshire clinics in 1972, a rate of 1.16/100,000 of the population. This was 6 cases more than the 5 cases in 1971. If early syphilis is not adequately treated the disease becomes latent for a period and later can cause serious complications, particularly of the heart and central nervous system. There were 11 new cases of late syphilis (1.16/100,000) attending Hertfordshire clinics in 1972, again an increase on 1971. The figures indicate that syphilis is not a major problem in this county or nationally at the present time.

There were 276 new cases of gonorrhoea reported from Hertfordshire clinics in 1972 (29.3/100,000), a small decrease over 1971. Gonorrhoea is more difficult to control than syphilis because of its short incubation period and because it is often symptomless in women.

The incidence rates for syphilis and gonorrhoea in Hertfordshire are approximately one-third of the national rate for these diseases. The national rate is boosted by the high incidence rates in the large cities.

The county health department provides specially trained health visitors who are attached to the venereal disease clinics to help with contact tracing.

The telephone answering service continues to be well used and in 1972 the following calls were received:—

St. Albans	.	.	29,830
Watford	.	.	18,379
Hitchin	.	.	4,306

A new answer phone was installed in the dacorum division in 1972, and in the East division in 1973.

The V.D. telephone messages are at present Watford 43369, St. Albans 64859, Hitchin 4130, Hemel Hempstead 65822 and Hoddesdon 66151.

Health education

Miss J. Wingfield, County Health Education Officer, reports:

During 1972 there was a continuing expansion of health education within the county. As it reached out to ever widening sections of the community increasing demands were made on the resources of the section and the work of the health education officer was becoming more of what it should be—that of initiator, co-ordinator, and professional advisor. Not only must he advise those who ask, he must make the most of every opportunity to promote health education whenever the opportunity presents.

Links with many organizations have been forged during the year. New contacts have been made and old ones re-established. Health education officers during the year have worked closely with colleagues in the local authority service and in the national health service, as the following examples show.

In collaboration with the nursing staff of the Maternity Department of the Queen Elizabeth II Hospital, evening sessions were arranged to which expectant mothers and their husbands were invited. The film “ Ready for Baby ” was

shown, and discussion was led by a midwifery sister and the health education officer. These sessions were planned as an introduction to parent-craft classes. There was an overwhelming response, and extra film sessions had to be arranged to accommodate the large numbers wishing to attend.

Health education liaison groups have been formed, the most recent in Mid Herts division, where one health visitor from each health centre or group practice met at 3-monthly intervals with the nursing officers and Mrs. Barron, the health education officer, to discuss and co-ordinate the current and future health education activities.

Mrs. Sheail, Health Education Officer, St. Albans division, writes:

“ A health education advisory group was formed and people invited to serve on the committee include representatives from industry, education, public health, the youth services, social work and local councils. Some aims of the group were to recommend fields of activity into which priority should be given and to consider ways in which the public might be made more aware of the value of health education.”

At the St. Albans Teachers' Centre a series of discussions on “ The Adolescent in Society ” involving health department staff and teachers took place in May.

Training

In-service training sessions have been arranged to introduce to a wide range of outside professional groups the health education section's resources. Training of field staff in projection techniques has continued. With the widening use of film as a teaching aid, it is important that staff undertaking practical health education should be proficient in techniques of projection and also in the correct use of film as an aid to teaching. In-service training of the health education officers has continued throughout the year.

Health education in schools

Health education in schools is frequently interpreted as being designed only for the children. In fact, health education within the schools situation should also involve various members of staff and the parents of the pupils. There has been an increasing number of meetings of health education officers with parent/teacher associations and with parents of children receiving specified health education courses. Such discussions with parents and staff are essential if effective teaching is to be undertaken, particularly in personal relationships and other topics where the influencing of attitudes is so important.

Whilst some schools do undertake health education on many health topics using a co-ordinated syllabus, the majority of assistance requested by school teachers is for help on isolated problem topics, such as venereal diseases, smoking, and drug abuse. While giving assistance with resource materials and sometimes taking part in the teaching, health education officers encourage teachers to incorporate these subjects into comprehensive health programmes. Health visitors and medical officers also take part in a variety of health education programmes for children, mainly within secondary schools. It is important that the various facets of health education being put over are co-ordinated, and there should be someone within the school to undertake this.

Mr. Pretty, Health Education Officer in the South West division, writes:

“ In co-operation with the Deputy Divisional Education Officer, a meeting was held for senior representatives from secondary schools to discuss the need for co-ordination of health education activities. It was decided that without an overall co-ordinator a number of things were likely to go wrong, including:

- (1) One aspect could be covered too many times.
- (2) Without a sound basis of knowledge formed in earlier years, later discussion was not useful.
- (3) As in all other aspects of the curriculum there was a need for balance between the years. Some aspects were best covered in early years, some in later years, but without co-ordination this principle was not necessarily observed."

Smoking and ill-health

The up-hill battle to prevent people from smoking cigarettes continued throughout the year. Education of a wide cross-section of the community about the health hazards of smoking was undertaken in all parts of the county.

Mrs. Barron, Health Education Officer, Mid Herts, reported that a major project was undertaken in Mid Herts early in the year on a number of different fronts:—

(1) Dr. Taylor, the Divisional Medical Officer of Health, wrote to 50 organizations offering speakers on the subject of "Smoking and Ill-health". Regrettably, only seven organizations asked for such talks.

(2) A tape recorded answer phone message was recorded by Marjorie Proops, to whom the department is indebted. This message was well publicized by the local press, and as a consequence, 1,200 calls were made to the answer phone by the public in the first six months of 1972. Positive response to the message, however, was poor. 44 callers requested further information, and only 4 callers expressed any interest in joining a group to give up smoking.

(3) A survey on the smoking habits of children was undertaken in 10 schools, and this indicated that the vast majority of children have accepted the message about the health risks of smoking. A question yet to be answered is why then are so many children with this knowledge still smoking?

(4) The management of a light engineering firm in Welwyn Garden City agreed to co-operate in a smoking project to be carried out amongst their employees. As in the other sections of the Mid Herts smoking project, the facts given about smoking were broadly educational and not just relevant to physical health, and the immediate aims were to encourage employees to look more closely at their reasons for smoking, and to help encourage a climate where non-smoking became the "norm", so making it easier for smokers to modify their habits or to stop altogether. In an attempt to evaluate the project, questionnaires were given to a sample of the work people before and after the project. A display was set up in the canteen for a week during March giving advice on how to stop smoking. Health education posters were displayed in rotation around the factory for a fortnight after the display, and contact was maintained with the health education officer for consultation and advice. Two bulletins were issued from the health education section, and the efforts by individuals and self-help groups which sprang up spontaneously were supported by the help of the factory nurse, who had herself given up after being a heavy smoker. The result of the evaluation indicates that overall there had been about a 10 per cent reduction in smoking, and many of the heavier smokers appeared to have cut down the number of cigarettes smoked. Later feed-back from the factory, however, would suggest that without continual support many smokers go back to old habits, particularly at the danger periods of holiday times.

Other anti-smoking activities

As part of the widespread health education programme on smoking and ill health, anti-smoking clinics with general practitioner referrals continued in the North Herts division.

In the Watford division, an answer phone message was made by David Hemery about anti-smoking to provide a stimulus for health education projects

in schools in the Watford area. Information about projects involving pollution and mathematical concepts were circulated to all these schools, together with details of the answer phone service giving Mr. Hemery's message.

Health education in industry

In the smoking project in the factory in Welwyn Garden City, co-operation at all levels was most encouraging. At another factory in Watford a project concerned with heart disease was not so successful, partly because of the absence of the factory nursing staff due to illness.

Mr. Pretty writes:

“ There can be no doubt that success in industrial projects depends on the availability and enthusiasm of staff within the factory. The health education officer can only be a catalyst to the total required effort.”

“ Well-being and Safety in Retirement ”

This was the title of a campaign in East Herts in which many agencies were involved. It culminated in a conference to which representatives of statutory and voluntary bodies were invited.

The exhibition theme was based on positive health and self help, and was designed to give every-day practical ideas, mainly for people with mild disabilities due to the ageing process.

Mrs. Coggins, Health Education Officer, East Herts division, states that:

“ Discussion went on when viewing the exhibition, and also during the coffee period. Several people met those who previously had just been names. There was surprise between various groups when it was realized that so many organizations care about the elderly.”

Another health education course on a similar theme was undertaken in Watford. This particular project, aimed at grandparents, caught the imagination of the press, resulting in publicity which eventually proved to be a good ally.

Mr. Pretty, Health Education Officer, comments:

“ The thinking behind the course was that few accidents are entirely physical in nature. In most accidents there are two factors—the psychological and the physical. Psychological factors such as depression, frustration, boredom and anxiety pre-dispose the accident victim to falling foul of the physical object which is commonly thought of as the sole cause of the accident.

One cause of psychological unease in elderly people is the lack of a clearly defined role. Previously they may have had a role in employment or a maternal role at home. A good deal of attention is being paid to the provision of activities for the elderly, but little attention has been given to helping old people find a purpose in life. It was decided on the course to consider the role of the grandparent as a role which could be seen as valuable and purposeful. Added to the psychological aspect of role was the specific content of the sessions which dealt with home safety with regard to the young and old, and with life-saving first aid.”

Further health education activities

Health education on many other topics has been undertaken in various forms—talks, films, competitions—to a variety of audiences, young and old. Speakers and programmes have been arranged to meet demand, but there are many groups of the community who make no demands for health education. Are these the people whose needs are the greatest? While health educators may feel there are many vulnerable groups in which health education is needed, it is

important that health education is also felt necessary by the group if successful health education is to be achieved.

Divisional medical officers commented on various aspects of health education activities during the year.

Dr. Hall, Divisional Medical Officer, North Herts, writes:

“ On the subject of health education, anti-smoking posters and leaflets have been displayed in health centres, and this was introduced as part of a programme for expectant mothers and their husbands. Smoking and health hazards as a subject was introduced into schools and colleges of education. Follow up of the smoking clinics took place.

Lectures have been given in schools and colleges of education, etc., on sexually transmitted diseases. Publicity was undertaken with regard to the telephone answering service on V.D. (Hitchin 4130) and posters placed at all known vantage points, including industrial firms.

On the subject of cervical cytology, posters giving times and places of the clinics were sent to all firms in North Herts, and publicity was given to this by the health visitors in the health centres.

Groundwork was put down in many schools in this division to include health education subjects in the curriculum, and lectures were incorporated in humanities projects.”

Dr. Earle, Divisional Medical Officer, East Herts, writes:—

“ Mrs. Bettie Coggins, an ex-teacher, was in charge within the division. Since she only works 20 hours a week, it is quite remarkable how much has been achieved.

Mrs. Coggins provided a short in-service training course for health visitors, district nurses and midwives, on health education methods. She has arranged a health education syllabus for some primary schools, in conjunction with teachers.

Education in personal relationships was carried out in some secondary schools and colleges of further education. Drugs, sex education and contraception, were common topics for teaching and discussion. Mrs. Coggins also ran a display in home safety and safety in retirement.

Health education was carried out in many other ways, by many other people. In Buntingford, the general practitioners and health visitors, provided health education sessions for the general public, on an ‘ Any Questions ’ basis.

Slimming clinics for adults were run in Bishop’s Stortford and Ware. These were for people with a medical need to slim. The general practitioners retained clinical control of their patients. The local authority provided the administrative backing and appropriate discussions.

Slimming clubs have been successfully run in some schools.

Courses in practical baby care were started by some health visitors. In some schools, domestic science teachers have taken over.

Anti-smoking: The continued demand for films shows the subject is still taught in schools. It is often included by science departments when environmental pollution is considered.

Venereal disease teaching: Sessions have been held in colleges of further education and many schools. Contact tracing is carried out by a health visitor. An answer phone message has been prepared, and we are now awaiting installation of the phone by the G.P.O.

Life-saving first aid was first taught to teachers in 1971. It has been followed through in 1972, and in 1973 there will be a further course for teachers. This will be particularly for those who are in charge of youngsters on expeditions, etc. This illustrates the continuity of health education in the division.

We have worked on the principle that it is better to try to meet demand than to work to a pre-conceived plan. Demands outstrip supply."

Dr. Norman-Taylor, Divisional Medical Officer, St. Albans, writes:

" Health education is another field of activity which seems to have become more firmly established during 1972. A health education advisory group was set up, and this has been a source of ideas and stimulation. This is an entirely unofficial body, members being drawn from various voluntary societies interested in health, from local councils and from interested officers. We also have a close working relationship with the teachers' centre, and two series of discussion groups on health topics have been held. This two-way exchange has been of great value in clarifying the ideas of the staff of both departments as to the desirable aims of health education in schools and how these can be met. An interesting new venture has been a request from the supervisor of the adult training centre for help with health education among the mentally subnormal adults working there. This has required a great deal of careful thought and planning. The health education officer has also continued to make herself available to parent/teacher groups, voluntary societies, etc., and she is the convener and secretary of the local working party on drug abuse. One of the functions of the health education section is to provide publicity for the various activities of the health department, and in this connection mention might be made of the campaign to bring more working women to the cervical cytology clinic at Boreham Wood. Thanks to the willing co-operation of most factory managers, a brief letter from the divisional medical officer was enclosed in each woman's pay packet. This produced a very marked increase in attendance. The V.D. answer phone continues to be used and the number of calls registered during the year was 29,830."

Dr. Shaw, Divisional Medical Officer, South West Herts, writes:

" Since the appointment of a full-time divisional health education officer the work has proceeded at a rapid rate. A great deal of work has been done with the Education Department to the extent that a number of teachers in this division have been identified as being very enthusiastic about the potential of health education in schools. In view of the importance of health education, I wonder whether it would not be possible for the Education Department to create special responsibility posts for health education in the same way as exists for other subjects. It should certainly be possible for the Health Department to provide the expertise to ensure continued training for such teachers.

Health education directed to the ill-effect of smoking continued throughout the year. This is a subject which has been treated in a variety of ways over the years and it is a matter of continuing with basic facts and trying to treat them in a different way. This year we had an answer phone message recorded by David Hemery, the Olympic gold medallist, and continued this with publicity in the local press, ' Watford—Our Town ' and ' Bushey News '. There were a gratifyingly large number of calls to the answer phone and a number of projects carried out in schools.

Work also continued in a number of factories and departmental stores on the subject of ' Keeping healthy in Middle-age '. A poster was specially designed by a member of the staff of Sun Printers, which proved so successful that requests for copies are coming in from all over the county. In view of the importance of heart disease as a cause of death in the middle-age an ' anti-coronary ' project is to be started in 1973 and we have been fortunate in obtaining the co-operation of Mr. Bobby Charlton, O.B.E., in publicizing the project.

There have been no specific campaigns on venereal disease throughout this year but work nevertheless continues at a high level in schools and other places. There is also wide advertising on the availability of cervical cytology."

Drug dependence

The Hertfordshire Standing Conference on Drug Dependence and its Executive Committee continued to co-ordinate the activities of statutory and voluntary bodies with parts to play in the prevention of drug abuse and in the past 12 months there were six meetings held.

Dr. J. D. Wright for Wolverhampton County Borough Health Department showed the film which had been made in the Borough "One Way Ticket". This gave a dramatic view of the drugs problem generally and the subsequent question and answer session proved how serious the problem had become. More than 40 members from the Standing Conference and from interested statutory and voluntary organizations attended this film showing which was aimed at the 14-17-year-olds and covered the dangers of L.S.D., cannabis, amphetamines, and barbiturates.

At the next meeting of the Standing Conference Professor W. D. M. Paton, C.B.E., Professor of Pharmacology of Oxford University spoke on the "Dangers of Cannabis Smoking". The real dangers arising from cannabis smoking were the impure nature of cannabis and as it was fat soluble its effect was cumulative. From research experiments undertaken on rats it was shown that cannabis can result in birth deformities and can kill the foetus. It also affects the metabolism of the liver and exacerbates barbiturate poisoning. Professor Paton said that his main concern was with cannabis' long term affect on the brain. This session was also well attended with more than 50 people present.

Nearly a hundred people attended the talk given by Miss Eleanor Murphy, Principal Probation Officer—the London Borough of Ealing when the theme was the "Role of the Probation Service in the Drug Problem". She felt that the existing penal system was harmful in certain instances to the drug taker and that better results could be achieved by keeping the addict within the sphere of the mental health services.

It was clear that the probation service could make a valuable contribution to the prevention and treatment of drug addiction by work in the courts, hospitals, and community particularly so at the diagnostic stage.

At this session Dr. Christine Saville, C.B.E., formerly Senior Medical Officer in the prison service, attended and gave valuable advice on the ways the prison service was dealing with the drug problem. It was imperative to get the addict drug free physically and then to help him psychologically and with this in mind units had been established at two prisons and these were showing good results.

Five weekly sessions were held in Mid Herts early in the year with Dr. Chappell, National Addiction Research Unit, Chief Inspector Jeffries of the Home Office Drug Department, Dr. Rathod of Roffey Park Hospital, Horsham, and Dr. Mitchell of Addenbrookes Hospital, Cambridge, as the speakers. These sessions were organized by the Mid Herts Working Group which was particularly active throughout the period.

At Executive Committee level a number of matters received attention during 1972. These included the desirability of establishing a drug treatment centre at Stevenage when the Lister Hospital was fully functional, the future of Roe Hill House, Hatfield, as a drug rehabilitation hostel, a revised constitution for the proper functioning of the Standing Conference and its Executive Committee, the receipt of progress reports from the six health divisions re problems arising in the day to day co-ordination of drug dependence. The police made frequent reports on prosecutions which had taken place within the area covered by the Hertfordshire Constabulary and the effect reorganization of the National Health Service would have on the work of the Standing Conference was also considered.

A sum of £50 was received from the Charities Aid Fund and this was sent to the Mid Herts Working Group to assist with their activities.

Drug abuse in Mid Hertfordshire

Dr. G. Taylor, Divisional Medical Officer, Mid-Herts, presents the following report:

Drug taking by young persons continued to present a fickle and changing pattern depending upon the behaviour trends produced by the demands of modern society within the family and community, and the availability of drugs.

During 1972 the availability of heroin from the central London areas was substantially reduced following intensive police action. The injecting of heroin thus remains mainly confined to the group of long established drug takers which tends slowly to decline in numbers as they find the drug increasingly expensive and difficult to obtain. Some are now making determined efforts to overcome their addiction with the help of medical care and social work support while others, now regular attenders at the addiction clinic, have reduced their drug needs while making determined efforts to establish their family and working relationships on a sound basis. Unfortunately morale and determination can readily wane so the path to rehabilitation for these young people seems strewn with overwhelming hazards, particularly the temptation to drink to excess in an attempt to overcome their feeling of social inadequacy. Those who fail to achieve any lasting improvement can be identified as a relatively small group of deviant and inadequate critics of the society in which they find themselves unable to achieve a worthwhile role. Increasingly ostracized by their families and friends, they seek temporary support in small groups from place to place, causing concern to the housing authorities and needing occasional urgent support from the social workers and voluntary supporting agencies.

One or two such groups containing married couples with children have required particularly careful supervision by the social workers and a selected health visitor who have protected the children while endeavouring to prevent the complete breakup of the home until the immediate problems are overcome. Sooner or later these deviants run into difficulties with the law and are sentenced to periods of detention so the membership of the groups and relationships within the group slowly change occasionally for the better. The element of display and the problem of injecting in public places which caused such concern two or three years ago has now largely disappeared so that the practices of these injectors are not advertised so blatantly.

The smoking of cannabis by groups of friends mainly between 16 and 22 years of age continues to be prevalent either in the teenager's own room at home or surreptitiously elsewhere. In spite of the warnings given by eminent authorities there are many parents who either condone or turn a blind eye to the evidence of cannabis smoking by young persons in the home and who make inadequate attempts to meet their children's protestations regarding the harmlessness of cannabis by providing more mature advice regarding the undesirable long term effects of reefer smoking.

The availability of amphetamine tablets has steadily declined now that the prescribing of preparations containing amphetamine has almost ceased. Early in 1972 the police department expressed concern regarding the amount of amphetamine in Hertfordshire following a break in, but the recent situation has shown a gradual decline in the availability of this group of stimulants. In Hatfield the sniffing of an adhesive glue is reported now and again among young people of 14-18 years of age.

While the use of hallucinatory drugs, particularly L.S.D., cannot be said to be a real problem as yet, there has been a gradual increase in the availability of L.S.D. throughout the county over the past 18 months, particularly the micro dot tablets. In the majority of instances the L.S.D. is taken as an experiment or thrill by young people seeking to experience the bizarre psychic release. They usually lose interest after two or three such episodes without incurring any serious harm. The main danger from L.S.D. would seem to be the acute risk of accident and injury while the young person is under the influence of the drug when judgement and orientation are impaired, and also the extreme terror and

alarm which can arise through the so-called "bad trip". This is extremely unpleasant and leaves the subject mentally rattled and alarmed for several weeks. With more frequent use of the drug a serious form of "bad trip" can occur when L.S.D. produces a psychotic state and in a proportion of persons this psychotic disturbance can continue for a long time with the occasional "return trip" when some of the feelings experienced under the L.S.D. seem to come back to the mind leaving the person alarmed and disorientated. There is no evidence that Mid Herts is more heavily involved with L.S.D. than the rest of the county and psychiatrists report that there has as yet been no increase in referrals of young people in psychiatric difficulties due to the taking of L.S.D.

With the increasing scarcity of heroin and amphetamines many young people caught up in the drug scene turn to a wide variety of barbiturate, hypnotic and sedative drugs in an effort to overcome their emotional problems, feelings of social inadequacy and physical ailments. Usually the drugs are selected according to availability with scant attention to the quantity taken and the hazards of taking several potent drugs and excessive drinking at the same time.

Attendance at the addiction centre in Welwyn Garden City increased early in the year, a total of 63 young persons seeking advice and support throughout the year. The staff at the centre has been increased to meet this additional workload providing a link with the whole range of treatment and rehabilitation by the hospital, social workers, Roe Hill House and voluntary services. 52 young persons were admitted to the psychiatric wing of the Queen Elizabeth II Hospital during 1972 for treatment of their drug addiction, where usually there are some 6-8 under treatment at any one time for periods of 3-8 weeks. Although volatile and unpredictable in their behaviour they usually co-operate well in their early withdrawal from drugs with the help of an experienced team of psychiatrists, nurses, and social workers.

At Roe Hill House determined efforts were made throughout the year to build up the number of residents engaged in group activities at first largely confined to the centre and under close supervision, later extending into outside rehabilitative occupation and placement in work situations. The applications are considered at the fortnightly meetings of the selection panel consisting of the staff of the house, with a consultant psychiatrist, a representative of the Richmond Fellowship and senior officers of the Health and Social Services Departments, the majority of the referrals being from the psychiatric wing of the Queen Elizabeth II Hospital where the applicants have been undergoing medical treatment for withdrawal from drug taking. In the absence of any firm requirement to remain at the house for the full length of time necessary for rehabilitation the majority of residents find themselves unable to accept the terms laid down for the continued residence after 2-3 months and leave, some to return later for a further stay, others to relapse quickly to their former ways. It has therefore not proved possible to build up the group above 6-8 residents with frequent changes in membership but there is no doubt that those who have joined the group for only a short period or a return stay obtain lasting benefit from their residence at the house.

Dr. Hedley, the Warden of the house, resigned at the end of the year on taking up addiction work at a hospital centre in London.

Mention should be made of the support provided by Mr. Harper, the unattached social worker, and Miss Sheppard, special social worker for the young, who were deeply involved with helping forlorn young people in acute difficulties throughout the year. The activities at Bridges, which is an office and meeting place for young people where they can get advice and information, and the advice and understanding provided there are often the sole immediate refuge and support for the few who by their own efforts fail to avert complete breakdown and rejection by their families and fellow drug takers. Temporary dormitory facilities for those unable to find refuge were made available at Bridges during the year.

The heads of all schools in Mid Hertfordshire are now well aware of the direct problems and most schools have incorporated regular advice on the dangers of drug taking as part of their personal and community relationships courses. Several of the heads have expressed concern at the increasing number of children in secondary schools who seem to be at risk of drug taking, especially those from broken homes, and homes where parents do not provide the continued support and guidance which their children undoubtedly need during the difficult years of adolescence.

The Mid Herts Working Party has played a very important part in general publicity this year. The regular meetings are well attended and the addresses given by leading authorities on the drugs situation at Hatfield in the spring were well received by a professional group of some 45 teachers, doctors and social workers. The working party has a very successful parents' group, arranges to review literature and films relating to drug taking and produces the "Drug Scene", a six-monthly news letter with information provided mainly from people working on the drug scene in Mid Hertfordshire.

Reviewing the progress achieved during 1972 gives ground for confidence in the future for the interest of professional staffs, voluntary workers and the general public has been well maintained with co-ordinated effort over the whole range of preventive and rehabilitative activities. The availability of heroin has been reduced and there has been no extension of the habit of injecting addictive drugs by young people. The use of cannabis and the hallucinogens, particularly L.S.D., may shortly decline as the fashion for experimenting with these drugs declines to be balanced unfortunately by young people at parties drinking to excess. The working group is particularly valuable for its contribution to publicity and education in Mid Hertfordshire for it is surely in this direction that our efforts, especially in schools and among parents of young children, will produce the most promising and lasting results.

Dietitian

Mrs. Horner resigned in December, 1972, and Miss J. Okell replaced her as county dietitian in December, 1972.

Miss Okell reports

The pattern of work set by Mrs. Horner in 1971 was continued and expanded during 1972.

The dietitian fulfills three functions:

- (1) To act as specialist adviser to her professional colleagues on matters of nutrition and diet.
- (2) As a health educator to various adult groups and school children.
- (3) The more traditional role of the dietitian in helping individual patients or groups of patients with dietary advice.

The dietitian has been pleased to attend divisional staff meetings when items were discussed concerning school milk, nutritional state of the school child, etc. She was able to liaise with the school meals service by participating in training courses for cooks as well as in cases of individual dietary problems at school meals. There have been many meetings with nursing officers, health visitors, and district nurses to discuss the nutritional aspects of various categories of patients and health care groups. There has been very valuable co-operation in many ways with hospital dietitians. There has been a very valuable and close link with social services with talks to groups of residents in homes, discussion with staff, cooks and more formal talks during in-service training sessions. Advice has been given to several meals on wheels centres.

During the year talks have been given to many women's clubs and organizations on various aspects of nutrition. Talks have also been given at ante-natal

clinics and two talks were given to dietetic students on the work of the dietitian in the community.

The dietitian has from time to time given dietary advice/diet sheets to individual patients at the request of the general practitioners. Much work has been done in slimming clubs where the dietitian has been part of a team with the doctors and health visitor. These clinics were run by the health visitors and the patients were mainly women referred by their general practitioners or health visitor. The "slimming course" takes the form of group sessions held once a week for 8–12 weeks, during which time the dietitian visits at least twice. There were also talks by the doctor, physiotherapist, and health visitor. An analysis of this work will be carried out after a year to assess the value of these clinics. No clinics for men have as yet been set up but it is hoped the whole family will benefit from "Mum's" attendance at the clinic. A number of slimming clubs operate at schools, run by the school medical officer and health visitor with occasional visits from the dietitian.

A summary of the main items of work is given below.

Meetings with health visitors, district nurses, and midwives	20
Visits to old people's homes	2
Meetings and talks to home helps	8
Talks to old people and physically and mentally handicapped	6
Health education meetings attended, and informal meetings with health education officers	15
Visits and talks to meals on wheels organizers, voluntary organizations, old people's clubs	11
Visits to mental hospitals, day care centres, adult training centres, hostels, etc.	17
General practitioners visited	5
Visits and meetings with hospital dietitians and consultants	6
Meetings with Divisional Medical Officers	7
Meetings and talks with the School Meals Service	4
Informal meetings with Divisional Nursing Officers	8
Outside meetings and conferences attended	9
Visits made to schools, including school slimming clinics	18
Domiciliary visits	9
Visits and attendance at county slimming clubs	51
Visits to anti-smoking clinics	2
Meetings of the Coeliac Society and Diabetic Association attended	3
Women's clubs and organizations for professional people	11
Lectures to Social Services training schemes	5
Talks to ante-natal and mothers' clubs	3
Lectures to nurses in training for health visitor, district nurse, pupil midwives, and field work instructor courses	12
Outside talks to dietetic students	2

Renal dialysis

Three houses were adapted during 1972 to enable patients to carry out renal dialysis at home. This now makes a total of 24 patients in the county who have been helped in this way since home dialysis was found practicable some six or seven years ago. In each of the three adaptations it was possible to convert an existing room in the house to form a treatment room.

Ambulance service

The county council has always endeavoured to maintain a high standard of efficiency in its ambulance service and this year has been no exception.

Increased facilities have been provided by the purchase of a tail hoist ambulance, a night cover ambulance for the northern area of the county based

at Stevenage, and a tail hoist ambulance for the south western area based at Watford.

In the communication field, a phased programme of a planned telex communication system has been completed with telex machines installed at 16 stations within the county. With this facility, pre-planned work and service information can be passed to all major stations, thus eliminating the lengthy manual procedures which have hitherto been undertaken.

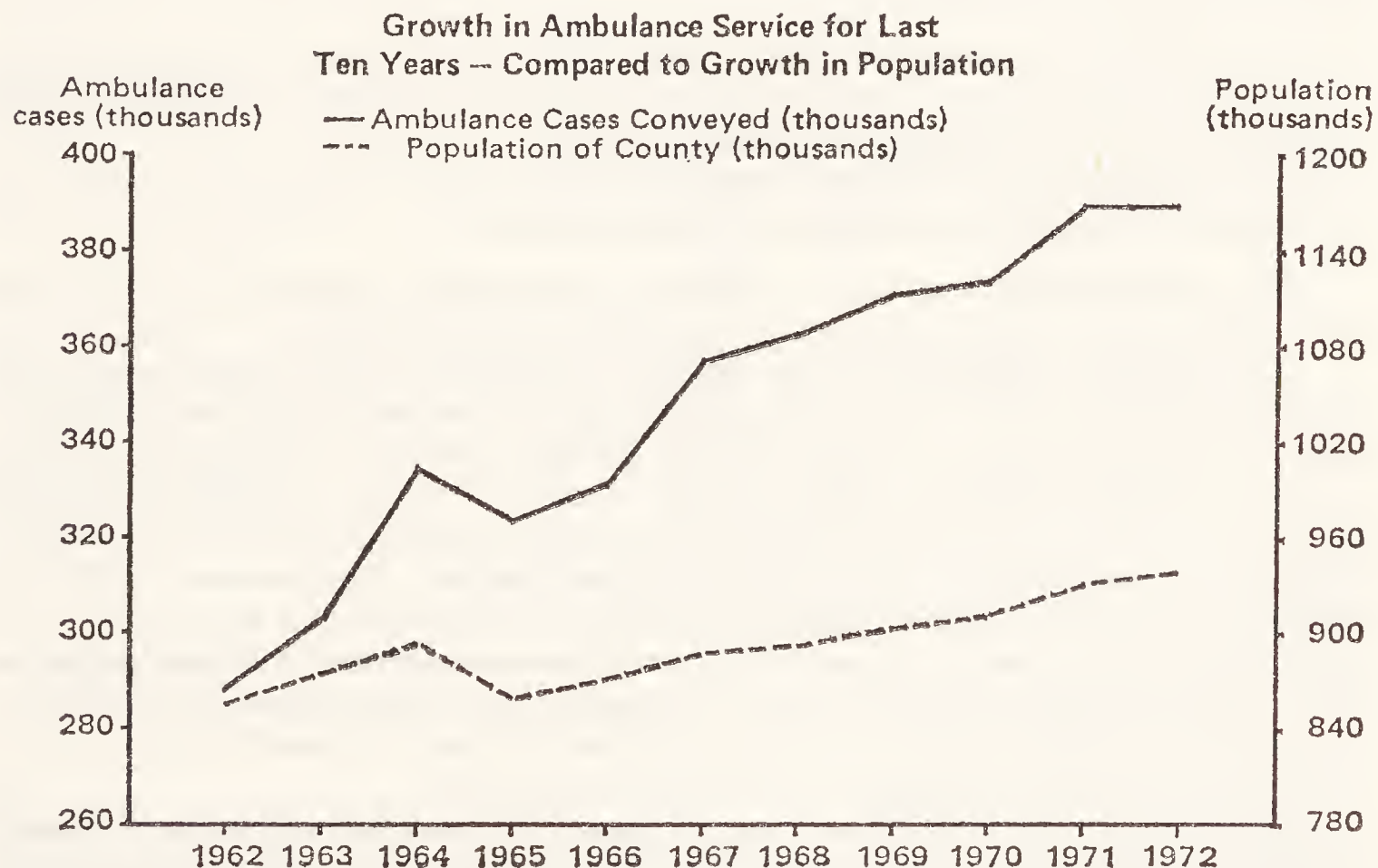
In anticipation of the separation of the fire and ambulance services, a communications officer has been appointed to deal with radio, telephone, and telex communications, which has been previously dealt with by fire officers.

For ambulance operational work, additional section officers were appointed at the main ambulance stations. They are responsible for operational, administrative, and supervisory duties again in relation to the separation of the two Services and work undertaken previously by fire officers.

The Department of Health and Social Security has given approval to the inclusion of the building of the new Letchworth Ambulance Station in the 1972-73 capital programme. It is intended that this station will cover the area of Letchworth and Hitchin and will serve the Lister Hospital.

There has been a further increase in the demand on the service compared with last year. The following graph shows the demand on the service during the last 10 years with the growth of population.

During 1971, the number of patients carried by the directly provided service showed an increase of 4.99 per cent with an increase in mileage of 3.99 per cent. In 1972, the number of patients carried showed an increase of 0.49 per cent with an increase in mileage of 1.92 per cent. Factors such as longer patient journeys and lack of British Rail facilities for stretcher cases have influenced the extra mileage figures.



The table below shows the number of patients carried and the mileage involved in respect of the directly provided service, hospital car service, and agency service, for the years 1971 and 1972.

Table 20

	1971	1972	Increase or decrease	
<i>Patients.</i>				
Directly provided service	356,639	358,406	Increase	1,767
Hospital car service	29,837	29,183	Decrease	654
Agency (Garston Manor Rehabilitation centre vehicle)	2,462	2,209	Decrease	253
<i>Mileage.</i>				
Directly provided service	2,180,494	2,222,562	Increase	42,068
Hospital car service	695,879	716,408	Increase	20,529
Agency (Garston Manor Rehabilitation centre vehicle)	6,923	6,515	Decrease	408

Health information and research unit

Research has formed an integral part of the function of the Health Department since 1964 through the activities of the members of the Research Panel. In late 1971 it was realized that if the research and information services were to expand as would be required by the reorganized health service in 1974, there would need to be an expansion of these facilities in the department. The Health Committee agreed, therefore, that an epidemiologist should be appointed to take charge of a new unit, the Health Information and Research Unit, the functions of which would be:

- (1) To capture, process, and interpret routine health data and from this provide more effective information to managers, clinicians and, through the health education section, the general public.
- (2) Where routine data sources were insufficient, to advise on and carry out epidemiological and operational research projects.

The epidemiologist would in addition assume responsibility for the health education section, and would act as consultant epidemiologist.

The Health Information and Research Unit (H.I.R.U.) was created in April, 1972, when Dr. G. Cust was appointed the Director of the unit. The first nine months have been very much involved with a review of the existing data sources in the department, together with a study of the likely fields of expansion in health services, and in the information needs resulting from these changes. Health service reorganization naturally figured large in this review. With the establishment of the Hertfordshire Joint Liaison Committee at the end of July, 1972, much of the time of the unit was taken in providing and collating information from the three branches of the service for the Joint Liaison Committee. The Director of the unit was co-opted to the Steering Committee of the Joint Liaison Committee in order to co-ordinate this work.

Time and staff available for research were minimal during the year, though the unit has taken over the functions of the old Research Panel, and the duties in relationship to research include:

- (1) The Health Information and Research Unit to carry out research projects itself.
- (2) To help other members of staff carry out research projects both by advice and practical help.
- (3) To advise and help outside bodies who are carrying out research projects in the health field in Hertfordshire.

During 1972 the unit was able to help Dr. Lax of the Kennedy Galton Research Centre in some work she was carrying out on severely subnormal children, and to help the Disabled Living Foundation in a study of the management of incontinence in the home. The data from the Mid Herts smoking project was analysed during the year, and a survey on the health visitor's views on the need for a domiciliary family planning service was carried out. A survey on parental smoking and upper respiratory tract infection in 5-year olds was published in "Community Medicine" by Dr. Norman-Taylor and Mr. V. Dickinson. (Taylor and Dickinson, 1972, Community Medicine 127, 32.) The evaluation of the effectiveness of whooping cough vaccines, a joint survey with the Public Health Laboratory Service, continued in 1972. The unit has co-operated with Dr. Marshall and Dr. Poole on their study "Prevalence of Obesity in School-children" in the Dacorum division by providing advice and data processing facilities.

Table 21 Nursing staff—position at 31st December

Staff	1972		1971		1970	
	No.	Whole-time equivalent	No.	Whole-time equivalent	No.	Whole-time equivalent
<i>Midwifery</i>						
District midwives	9	81.40	11	83.50	13	71.50
District nurse/midwives	113		111		112	
District nurse/midwives/health visitors	17		16		19	
<i>Health Visiting</i>						
Health visitors	152	138.50	172	168.87	155	147.00
District nurse/midwives/health visitors	17*	5.10	16*		19*	
Health visitor assistants	82	38.00	76		60	34.43
Tuberculosis visitors	5	4.50	5	5.00	5	5.00
<i>District Nursing</i>						
District nurses	100	87.70	99	89.60	84	141.00
District nurse/midwives	113*	34.60	111*	44.00	112*	
District nurse/midwives/health visitors	17*	6.10	16*	5.80	19*	
State enrolled nurses	34	33.70	19	19.00	16	
Auxiliary nurses	27	15.10	20	14.00	—	
	539	444.70	529	466.35	464	398.93

* The number of staff have also been included under "Midwifery."

Table 22 Notified births and stillbirths of Hertfordshire residents

	1972	1971	1970	1969
Total births and stillbirths	13,573	14,142	14,397	14,322
In hospitals	11,817*	11,529	11,256	10,742
At home	1,756	2,613	3,141	3,580
Percentage of domiciliary births	12.9	18.5	21.8	25.0

* 315 of these were delivered in hospital by domiciliary midwives.

Table 23 Patients discharged from hospital for district midwife care

	<i>Reports made on home conditions.</i>	<i>Hospital confinements.</i>	<i>Early discharge from hospital.</i>	<i>Total visits by domiciliary midwives.</i>
1968 . . .	3,300	10,631	4,975	22,441
1969 . . .	2,933	10,742	4,948	22,699
1970 . . .	3,947	11,256	5,049	26,828
1971 . . .	4,281	11,529	6,121	31,950
1972 . . .	4,215	11,817	9,481	Hospital dis- charges and domiciliary confinements 56,605

Table 24 Home nursing—types of cases and visits paid

	1972			1971			1970		
	Cases	No.	%	Cases	No.	%	Cases	No.	%
Medical . . .	13,356	313,697	77·80	11,188	284,806	77·20	11,606	295,525	78·61
Surgical . . .	4,280	84,274	20·90	3,917	76,909	20·85	3,488	73,730	19·61
Infectious diseases . . .	15	170	0·04	61	180	0·05	97	179	0·05
Tuberculosis . . .	34	1,257	0·31	39	852	0·23	26	656	0·17
Cytology . . .	35	56	0·02	29	60	0·02	72	138	0·04
Others . . .	544	3,748	0·93	788	6,105	1·65	1,188	5,723	1·52
Total: . . .	18,264	403,202	100	16,022	368,912	100	16,477	375,951	100

Table 25 Work undertaken by nurses in G.P. surgeries

	<i>Patients Treated</i>	<i>Cytology Sessions</i>	<i>Geriatric Sessions</i>	<i>Other Screening</i>
1972 . . .	58,985	314	60	1,852
1971 . . .	47,893	394	—	472
1970 . . .	29,544	219	—	477

Table 26 Clinic sessions attended by health visitors

Type of session	Local authority		G.P. surgery		Hospital		Total	
	1972	1971	1972	1971	1972	1971	1972	1971
Child health . . .	11,849	11,901	1,759	1,517	—	—	13,608	13,418
Vaccination and immuni- zation . . .	1,740	1,745	1,367	930	—	—	3,107	2,675
Geriatric . . .	—	—	228	120	84	57	312	177
Paediatric . . .	—	—	—	—	549	324	549	324
Tuberculosis . . .	—	—	—	—	709	716	709	716
Venereal disease . . .	—	—	—	—	325	267	325	267

Table 27 Home visits paid by health visitors

Type of visit	Number of 1st visits		Number of revisits		Total no.		Percentage of total visits	
	1972	1971	1972	1971	1972	1971	1972	1971
Children under 5 years .	65,623	71,112	106,162	111,677	171,785	182,789	72·1	73·4
Persons aged between 5 and 16 years . .	1,578	—*	1,237	—	2,815	—	1·2	—
Persons aged between 17 and 64 years . .	3,483	—	5,489	—	8,972	—	3·8	—
Aged over 65 years .	8,322	6,938	17,307	15,301	25,629	22,239	10·7	8·9
Mentally handicapped .	Included in above (279)	—	Included in above (833)	—	Included in above (1,112)	—	—	—
Mentally ill . . .	Included in above (709)	859	Included in above (2,245)	3,068	Included in above (2,954)	3,927	—	1·6
Physically disabled .	657	784	1,550	1,814	2,207	2,598	0·9	1·0
Expectant mothers .	3,759	3,425	1,380	1,161	5,139	4,586	2·1	1·8
Nurseries and child minders . . .	1,114	1,171	2,221	2,822	3,335	3,993	1·4	1·6
Pre-adoption . . .	—	314	—	499	—	813	—	0·3
Infectious diseases . .	330	207	233	114	563	321	0·2	0·1
School nursing . .	—	—	5,705	6,533	5,705	6,533	2·4	2·6
Tuberculosis } .	—	984	—	3,462	—	4,446	—	1·8
Tuberculosis contacts }	1,315	2,251	4,052	—	5,367	2,251	2·3	0·9
Tuberculosis B.C.G. .	—	383	—	—	—	383	—	0·2
Non-tuberculosis . .	—	314	—	384	—	698	—	0·3
Hospital discharges .	—	572	—	378	—	950	—	0·4
Others	3,189	4,100	3,855	8,488	7,044	12,588	3·0	5·1
	89,370	93,414	149,191	155,701	238,561	249,115	100	100·0

—* These figures are not absolute for both years because of changes in the dated collection forms.

Table 28 Reinforcing doses—number of persons under age 16

Type of vaccine or dose	Year of birth					Others under age 16	Total
	1972	1971	1970	1969	1965–1968		
1. Quadruple DTPP	—	—	—	—	—	—	—
2. Triple DTP	—	—	—	—	—	—	—
3. Diphtheria/Pertussis	—	—	—	—	—	—	—
4. Diphtheria/Tetanus	—	—	5	18	13,218	186	13,427
5. Diphtheria	—	—	—	—	—	—	—
6. Pertussis	—	—	—	—	—	—	—
7. Tetanus	—	—	9	7	87	4,654	4,757
8. Salk	—	—	—	—	—	—	—
9. Sabin	—	—	—	—	13,235	4,889	18,124
10. Lines 1+2+3+4+5 (Diphtheria) . .	—	—	5	18	13,218	186	13,427
11. Lines 1+2+3+6 (Whooping Cough) .	—	—	—	—	—	—	—
12. Lines 1+2+4+7 (Tetanus) . . .	—	—	14	25	13,305	4,840	18,184
13. Lines 1+8+9 (Polio)	—	—	—	—	13,235	4,889	18,124

Table 29 Congenital abnormalities notified, 1967-72

Year	Body system involved										Total cases	Rate/1,000 live and stillbirths
	Central nervous system	Eye or ear	Alimentary system	Heart	Respiratory	Uro-genital	Limbs	Other muscular skeletal	Other systems	Other malformations	Total abnormalities	
1972 .	61	3	21	6	3	22	142	14	19	12	303	20.6
1971 .	54	6	33	6	—	22	119	6	11	10	267	15.7
1970 .	57	6	32	5	1	19	127	6	25	21	299	17.7
1969 .	51	12	47	7	—	22	180	7	20	18	364	21.2
1968 .	54	7	44	27	2	27	186	12	10	24	393	22.5
1967 .	52	10	44	12	—	18	162	8	17	19	342	19.0

Table 30 Well woman clinics—number of women attenders and results, 1972

Division	(1) Number of women first attendances	Results of tests			(2) Subsequent attendances	Results of tests			(3) Re-test 3-5 years	Results of tests		
		Negative	For re-test	Further in- vestigation recom- mended		Negative	For re-test	Further in- vestigation recom- mended		Negative	For re-test	Further in- vestigation recom- mended
South-West .	908	557	346	5	293	259	34	—	245	151	92	2
East .	574	545	26	3	26	25	—	1	764	731	29	4
St. Albans .	913	777	132	4	386	228	157	1	1,146	982	163	1
Dacorum .	973	818	145	10	112	106	6	—	466	340	126	—
North .	721	639	79	3	—	—	—	—	982	857	121	4
Mid .	793	775	15	3	601	585	10	6	—	—	—	—
Total .	4,882	4,111	743	28	1,418	1,203	207	8	3,603	3,061	531	11

Table 31 Percentage of children with completed vaccinations by year of birth at 31st December, 1972

	1971	1970
Diphtheria-Tetanus	68.5	83.7
Whooping cough	66.9	81.5
Poliomyelitis	68.5	84.0
Measles	40.1	68.6

(Many children born in 1971 are not yet of an age that immunization will have taken place.)

Measles notifications (vaccination began in 1968)



Table 32 Vaccination of persons under age of 16 completed during 1972

Type of vaccine or dose	Year of birth					Others under age 16	Total
	1972	1971	1970	1969	1965-1968		
1. Quadruple DTPP	—	—	—	—	—	—	—
2. Triple DTP	78	8,939	2,499	104	107	—	11,727
3. Diphtheria/Pertussis	—	—	—	—	—	—	—
4. Diphtheria/Tetanus	1	259	180	51	59	3	553
5. Diphtheria	—	—	—	—	—	—	—
6. Pertussis	—	—	—	—	—	—	—
7. Tetanus	—	2	5	11	10	218	246
8. Salk	—	—	—	—	—	—	—
9. Sabin	85	9,267	2,589	162	198	48	12,349
10. Measles	9	5,269	3,753	426	1,690	45	11,192
11. Rubella	—	—	—	—	—	4,438	4,438
12. Lines 1+2+3+4+5 (Diphtheria)	79	9,198	2,679	155	166	3	12,280
13. Lines 1+2+3+6 (Whooping Cough)	78	8,939	2,499	104	107	—	11,727
14. Lines 1+2+4+7 (Tetanus)	79	9,200	2,684	166	176	221	12,526
15. Lines 1+8+9 (Polio)	85	9,267	2,589	162	198	48	12,349

Table 33 B.C.G.—school children (excluding those known to have received B.C.G. vaccination already)

	<i>Skin tested</i>	<i>Found positive</i>	<i>Found negative & Vaccinated</i>
East . . .	4,120	40	4,080
Mid Herts . . .	1,917	38	1,879
St. Albans . . .	4,736	105	4,631
South West . . .	2,903	94	2,809
Dacorum . . .	1,860	17	1,843
North . . .	2,306	84	2,222
	17,842	378	17,464
Chest hospitals . . .	63	5	47
	17,905	383	17,511

Table 34 Venereal diseases—incidence rates for 1967–72

<i>Hertfordshire.</i>			<i>England.</i>		
<i>Incidence of early syphilis seen at Hertfordshire clinics.</i>			<i>Incidence of early syphilis in England.</i>		
	Cases			Cases	
Year	Number	Rate/100,000	Year	Number	Rate/100,000
1972 .	11	1·16	1972 .	n/a	n/a
1971 .	5	0·54	1971 .	1,606	3·48
1970 .	10	1·10	1970 .	1,583	3·42
1969 .	10	1·11	1969 .	1,618	3·51
1968 .	13	1·46	1968 .	1,762	3·84
1967 .	8	0·91	1967 .	1,658	3·64
<i>Incidence of late syphilis seen at Hertfordshire clinics.</i>			<i>Incidence of late syphilis in England.</i>		
	Cases			Cases	
Year	Number	Rate/100,000	Year	Number	Rate/100,000
1972 .	11	1·16	1972 .	n/a	n/a
1971 .	6	0·65	1971 .	1,217	2·64
1970 .	18	1·97	1970 .	1,392	3·01
1969 .	18	1·99	1969 .	1,420	3·08
1968 .	21	2·35	1968 .	1,615	3·52
1967 .	21	2·38	1967 .	1,614	3·54
<i>Incidence of gonorrhoea seen at Hertfordshire clinics.</i>			<i>Incidence of gonorrhoea in England.</i>		
	Cases			Cases	
Year	Number	Rate/100,000	Year	Number	Rate/100,000
1972 .	276	29·3	1972 .	n/a	n/a
1971 .	282	30·3	1971 .	55,890	121·3
1970 .	317	34·8	1970 .	53,587	115·7
1969 .	219	24·2	1969 .	50,037	108·3
1968 .	194	21·7	1968 .	43,922	95·6
1967 .	172	19·5	1967 .	41,008	89·7

n/a—National figures for 1972 are not yet available.

III Environmental health

Mr. Stringer, County Health Inspector, reports:

Introduction

In my 1971 report, I made reference to local government change with a special reference to the need for maintaining a strong public health function in the new authorities. At that time, the Local Government Bill was still being debated in Parliament and it was not even clear whether the new county councils would take over the waste disposal function from the district councils as recommended in the Government's White Paper. The Local Government Bill became an Act towards the end of the year and we now know that the new county councils will be waste disposal authorities. It also appears that at least one of the county councils' duties under the Food and Drugs Act, 1955, that referring to the prevention of sale of tuberculous milk, together with milk from animals suffering from certain scheduled diseases, will become the responsibility of the new district councils. I shall have more to say about these changes of function in the body of this report, but the feature of present trends is that the public health inspector, or environmental health officer which appears to be the more fashionable title nowadays, will generally have enhanced responsibility within his own particular sphere and, with the principles of corporate management now being increasingly adopted, his influence should be felt more widely than ever before.

Milk and dairies administration

(a) Infection in milk

During the year, we continued our sampling activities at farms. Milk samples are subjected to the "ring" test which is a valuable guide to the presence or otherwise of brucella abortus, an organism which can cause abortion in cattle and undulant fever in human beings. A total of 249 farms were visited during the year and 34 of these gave positive "ring" samples. Altogether a total of 998 samples were submitted for tests of which 126 were positive. These latter figures merely show the amount of activity which this work entails as many of the samples taken were from individual cows in order to assist farmers to locate possible sources of infection. A three-cornered liaison scheme exists between the county council, the district medical officer of health (who has powers to stop the sale of milk or divert for pasteurization under certain conditions) and the divisional veterinary officer of the Ministry of Agriculture, Fisheries, and Food. Bulk farm samples are taken yearly from those herds where it is known that milk is sent for pasteurization and in the case of those farms where milk is retailed in the untreated (raw) state, samples are taken six times a year. The public health significance of "positives" from the latter group is obviously higher, hence the greater frequency of sampling. In the case of farms where milk is sent for heat treatment, the public health risk is much reduced although there is always a hazard to the farmer and his family and friends where a proportion of the milk is used for domestic purposes.

A growing number of farms in the county are now accredited under the brucella eradication scheme and there has been some criticism during the year that our sampling activities are duplicating those of the Ministry veterinary service. We therefore propose to alter our brucella sampling scheme next year to exclude those farms which are accredited and to increase the sampling of the raw milk retailing farms to once monthly.

The duty to prevent the sale of milk from tuberculous animals and from animals suffering from certain scheduled diseases is placed upon county councils and county borough councils by the provisions of the Foods and Drugs Act, 1955. The Foods and Drugs Act, 1938, carried similar obligations and for something like a quarter of a century this section within the County Medical

Officer's department has been responsible for operating what was once known as a "biological" sampling scheme. In those days, guinea pigs were widely used for the detection of T.B. and the brucella organism and the results were unambiguous. Following the introduction of schemes for the eradication of T.B. from bovines in this country, the public health priorities for the "biological" scheme have tended to diminish. Most milk supplies are now subjected to heat treatment of one kind or another, and the considerable increase in brucella-free herds has again shifted the priorities elsewhere. Generally, guinea pigs are now no longer obtainable for this type of sampling activity and the "ring" test, which is indicative of brucella infection without actually demonstrating the organism, has proved to be a useful guide. However, there are other scheduled diseases which are not detected by our present sampling methods and, short of veterinary examination of dairy herds, there appears to be no easy way of satisfactorily fulfilling the obligations implied by Section 31 of the Act. If all the scheduled diseases were made compulsorily notifiable to the appropriate local authorities, then follow-up action could be taken. There have been far-ranging discussions over the years to make brucellosis notifiable but this has never been done and the present eradication scheme is proceeding so rapidly that any arguments in the favour of notification are rapidly diminishing.

It appears that the new district councils will inherit Section 31 responsibilities after 1st April, 1974, which appears to be a tidier arrangement than the one at present in view of the fact that district councils already have certain powers relating to the compulsory heat treatment of infected milk or its withdrawal from sale altogether.

(b) Supervision of pasteurizing plants

The county council, in those areas of the county for which it is Foods and Drugs Authority, is responsible for licensing six pasteurizing plants and 255 distributors of milk. Pasteurized milk is subjected to both methylene blue and phosphatase tests, the former being indicative of keeping quality and the latter the efficiency of heat treatment. A total of 514 methylene blue samples were obtained of which 15 failed and a total of 512 samples for phosphatase testing produced three failures. In addition, tests applicable to U.H.T. and sterilized milks were applied to 45 samples and there was one failure. Follow-up enquiries were made where failures occurred, including out-county investigations through the appropriate licensing authorities.

(c) Milk in schools scheme and school canteen milk

A total of 169 samples were obtained for both the phosphatase and methylene blue tests. A total of 9 methylene blue failures were reported and one phosphatase failure.

Swimming pools

The interest of parent/teacher associations in providing funds for school swimming pools shows no signs of flagging. This, together with the county council's own programme to provide pools, has led to the number of pools doubling over the past 7 years and there are now a total of 120 school pools in the county and a further 62 under active consideration.

The experience gained over many years has meant that the design, construction, and running of pools has been progressively rationalized and refined (one hesitates to say perfected) to a high degree. As a result, although all the county council's officers involved constantly seek improvements, this year there is little new to report.

In the field of chlorination, chloroisocyanurates have been used very successfully over the past few years. This type of disinfectant is particularly suited to school use but has an inherent defect in that most pools need mid-season refilling in order to maintain the soluble residue from the material at an

acceptable level. An alternative method of utilizing the stabilizing effect of cyanuric acid is being considered and pilot trials will be run next season.

A total of 1,411 visits were made to school swimming pools during the year. Tests to detect chlorination levels and hydrogenion concentration (p.H. value) are made at the pool side.

Food hygiene in county establishments

It has been customary in the past to comment upon the liaison with the Education Department on food hygiene matters in the schools' meals service.

This liaison is still with us and contributes to the high standards of this excellent service. It is felt, however, that this advisory service should extend into other county council activities which involve the preparation of food. Since the creation of the Social Services Department and the appointment of additional staff, a point of contact has been established through which advice on food hygiene can be disseminated into that department's homes and other establishments. As a result of this work, the objective of a uniformly high standard in respect of food handling practice, equipment, and accommodation, will be ensured.

School pottery activities

Last year, brief reference was made to a survey carried out at a number of Hertfordshire schools and colleges of further education when an investigation was made into pottery activities. As a result, a code of practice to supplement an existing code circulated by the Department of Education and Science, was circulated to all headmasters in the county. Additionally, some modifications have been made to the architectural brief to improve conditions in school pottery rooms and to facilitate cleansing of floors and surfaces, etc. Much interest has been shown in the code of practice nationally, and it has therefore been included in the report.

Pottery rooms—code of practice

(1) To be read in conjunction with Administrative Memorandum No. 517—Restrictions on the Use of Certain Types of Glazes in the Teaching of Pottery, issued by the Ministry of Education, November, 1955.

(2) No fritted glazes containing lead should be used in primary schools.

(3) Where it is felt that dry glaze mixes have considerable advantages in schools and colleges, great care should be taken in mixing them. There should be the minimum amount of carrying and no dry glazes should be handled where draughts from windows or fan heaters can blow them about.

(4) Glazes should always be applied wet by dipping or brushing. Spraying of glazes should never be done at primary level, and if done in secondary or further establishments, properly designed spraying booths with mechanical extraction must be used.

(5) The fettling of glazes should be carried out with a wet sponge or knife; it should not be done with the fingers.

(6) On no account should dry grinding or fired glazes be carried out. If a hood with mechanical extraction is not available grinding should be carried out on stones which are continuously kept wet.

(7) Heavily used equipment, such as sponges, cloths, table tops, etc., should be washed as soon as practicable after use. It is far preferable to wash equipment which is already wet than to allow it to dry out and present a dust hazard.

(8) Great efforts should be made to keep the dust content in rooms down to a minimum. Dust and dried out clay should not be left to lie around.

(9) Plastic aprons should be sponged down at the end of each day's work and protective clothing washed weekly or more frequently if necessary. There are on the market now cheap disposable plastic aprons which schools may find convenient.

(10) Owing to the possible release of lead from hollow ware, such as cups, jugs, etc., which have been glazed with leaded frit, warning should be given that acid foods should not be used in conjunction with these vessels. For example, it is particularly undesirable to leave such liquids as lemonade or vinegar standing in glazed jugs for periods of several days.

(11) Food must never be taken into rooms where pottery activities are carried out.

(12) Manufacturer's instructions on the use of glazes, colouring materials, etc., should be observed.

(13) Only low solubility glazes as approved under Administrative Memorandum No. 517 should be used in schools. Primary schools should not use fritted lead glazes under any circumstances.

(14) No materials from outside sources (friends with studio potters' or trade contacts) should be taken into schools unless they comply with Administrative Memorandum No. 517, and this code of practice.

Refuse disposal

During the year, three consents were issued in respect of non-putrescible refuse tips and a further consent was issued for the reception of putrescible materials. In one case, a consent for a "putrescible site" was altered to include an additional area and, because of environmental problems at another site, the consent was modified to permit the dumping of putrescible material in a limited area, the remainder to be filled by non-putrescible refuse. All these consents were issued by virtue of the powers contained in the Hertfordshire County Council Acts, 1935 and 1960.

During the year, the Deposit of Poisonous Waste Act became operative as a result of considerable public outcry at the irresponsible dumping of poisonous wastes in certain areas of the country. We have been fortunate in having the Hertfordshire County Council Act provisions to enable consents to be issued which, because of our geological vulnerability, have excluded the dumping of toxic waste. While most wastes have some degree of toxicity (no one would pretend that a person's health would be improved by consuming a dustbin-full of domestic refuse), the controlled difficulties are to establish what materials are acceptable and what are not under given conditions of tipping. It is perhaps unfortunate that the word "toxic" has been used so widely to describe hazardous materials whose effect may be far from poisonous to the environment but, nevertheless, undesirable. In the past, we have experienced problems associated with the disposal of strongly colouring solutions which, had they gained access to a water supply, would have caused a public outcry. Phenolic substances are well known for the undesirable taste which they can produce, even in vast dilutions, especially when associated with terminal chlorination, which is widely practised. The formation of chlor-phenols are said to produce taint detectable by some in dilutions as great as one part in one hundred million. Modern civilization has resulted in the humble subject of refuse disposal taking on an entirely new and sophisticated aspect when knowledge of industrial chemistry, hydrogeology, ion-exchange processes, degradability, and so on, are discussed by experts without so much as batting an eyelid.

To return to the Deposit of Poisonous Waste Act. The general prohibition on depositing poisonous and other dangerous waste came into operation on 30th March, 1972, while the notification procedures, by Regulation under the Act, came into operation on 3rd August. The district councils are responsible for implementing the Act and the Regulations made thereunder, and notification

of the removal and depositing of non-exempted waste must be made to them and to the appropriate river authority. By the end of the year, enquiries showed that the controls which had been established under our own private Act legislation had been effective and notifications of the non-exempted wastes indicated that these were being traditionally disposed of outside the county in areas of greater geological safety. While notification procedures are of considerable interest in establishing what sort of wastes are being produced by industry which can be regarded as hazardous, it is obvious that further controls will be required nationally, perhaps much on the lines of those which we have enjoyed privately. Both the Key and Sumner Technical Committee reports, the former dealing with toxic waste disposal and the latter with the disposal of refuse generally, recommended that the larger local authority units should be responsible for controlling the disposal of wastes. It remains to be seen what powers are given to the new county councils to increase the effectiveness of their controls and, at the time of writing, it is known that these matters are under intensive discussion.

Dr. Taylor, Divisional Medical Officer, Mid Herts, reports on environmental pollution with lead in Welwyn Garden City:

“Following consultation with Dr. A. E. Martin of the Department of Health and Social Security in January, 1972, an epidemiological investigation was undertaken into the blood lead levels of young children from families living in close proximity to the factory of the British Lead Mills in Peartree Lane. In order to conform with similar investigations being undertaken in other centres in the country where lead smelting plants are in operation, it was decided to investigate three categories of children:

- (a) From families living in the immediate vicinity of the British Lead Mills, in Peartree Lane, Ravenfield Road, Hyde Way, and Ludwick Way.
- (b) Children of employees of the factory.
- (c) Children from representative families living in all parts of the town.

Dr. B. Clayton of the Department of Biochemistry at the Hospital for Sick Children, Great Ormond Street, kindly agreed to undertake the micro-estimations and it was decided to include children up to six years of age in the samples.

The following table summarizes the main findings in this investigation:—

	<i>No. of children</i>	<i>Mean Blood Lead mgms/100 ml</i>	<i>No. above 40 mgms/100 ml</i>	<i>Highest level mgms/100 ml</i>
General Survey	95	28·7	8	52
Residents in close vicinity of Lead Mills	25	30·1	5	46
Children of employees of Lead Mills	12	43·8	7	78
Children of employees of Bourne Chemicals, Limited	10	21·5	—	34

The general survey of the town included four children known to have a high risk as three of them were children of past or present employees of the British Lead Mills and one lived near to the British Lead Mills in Ravenfield Road. If these four children are excluded from the general survey a total of 91 children not known to be at special risk had a mean blood lead level of 27·8 micrograms/100 ml.

Significance of the blood lead levels

Recent limited surveys of young children in British towns show mean blood levels between 22 and 27 micrograms/100 ml. with a range from 15 to 40 micrograms. The threshold level for potential clinical poisoning is difficult to assess

as blood lead levels in children show substantial short-term fluctuations. Levels in the range 37–50 micrograms are now regarded as undesirable and may over a long period be associated with clinical symptoms of poisoning. Levels above 80 micrograms/100 ml. indicate that lead encephalopathy is imminent.

The main concern was felt at the relatively high blood lead levels of the children of employees and staff of the British Lead Mills. Those with levels above 45 micrograms were carefully examined at their homes but no clinical evidence of ill health or signs of toxic effects from their high lead intake could be found. With the co-operation of the medical practitioner the young boy of two years of age with the blood lead level of 66 micrograms was admitted to the Hospital for Sick Children, Great Ormond Street, for repeat blood lead estimation, full clinical examination and to withdraw him from the harmful home environment. The hospital reported a blood lead level of 78 micrograms which fell to 54 micrograms on discharge from hospital 10 days later. No clinical or radiological evidence of toxic effects from his high lead intake was found and he has remained in good health.

Careful inspection of the homes of the three families where children had blood lead levels above 50 micrograms failed to disclose any obvious local source for the high lead intake. It was noticed that these families did not possess an electric vacuum cleaner for the carpets, although the homes were clean and well maintained, the living room carpets being brushed regularly. Samples of dust obtained from the living room carpets in these homes by vacuum cleaner and examined at the Department of Trade and Industry showed 2·0–2·2 per cent of lead in the dust and 1·5 per cent in the fluff presumably deposited from the shoes and clothing of the husbands returning from their work at the Lead Mills.

The results of the blood lead samples and enquiries in the homes were discussed with Dr. Trevarthen, the Works Medical Officer, and Mr. Plumer, the Works Director, who drew the attention of the management to my concern at the evidence of contamination of the homes of some of the employees with lead. Attention was drawn to the need for higher standards of orderliness and cleanliness of the factory buildings, yards and runways, the resurfacing of runways and stricter attention to the hosing down of these areas. The need for strict attention by all employees to the factory rules for the changing of shoes and clothing, the wearing of protective clothing at work, and the regular washing and renewal of these working clothes as well as strict attention to the use of the washing facilities and showers at the works before returning home, was also emphasized.

A detailed report of these findings has been prepared for Dr. Martin for inclusion in his survey of all areas in the country at high risk from lead pollution. In Welwyn Garden City studies will continue particularly to ensure that the better observance of precautions against contamination of employees at the British Lead Mills have overcome the hazard of lead dust being carried into the home on shoes and clothing."

IV School health

School health service

Medical inspection

The organization of the routine surveillance of the health of children attending school in the county remained unchanged. After routine full medical examination of all children during the first year at school, further routine medical examinations are done on a selective basis during the child's first and final year of secondary education. Children are selected for these medical examinations on the basis of medical history and information from questionnaires to parents and consultation with the head teacher. Follow up examinations (re-examinations) are carried out as necessary and a child can be referred to a school doctor at any time by parents or with the consent of the parents by a member of the teaching or nursing staff.

Table 35 Medical inspections

	1972.	1971.
Number of pupils on registers of maintained Primary, Secondary, Special and Nursery schools.	181,094	177,927
Number of periodic medical inspections	21,928	21,107
Number of special inspections	2,709	3,293
Number of re-inspections	18,629	17,056

Table 36 Defects found by medical inspections

Defect (1)	Number of Defects							
	Already under treatment (2)		Recom-mended treatment (3)		Total (4)		Under observation (5)	
	1971	1972	1971	1972	1971	1972	1971	1972
Skin	173	166	85	56	258	222	607	674
Eyes :								
(a) Vision	397	371	423	310	820	681	550	560
(b) Squint	217	186	70	55	287	241	274	282
(c) Other	18	24	10	11	28	35	110	129
Ears :								
(a) Hearing	117	138	118	112	235	250	839	907
(b) Otitis Media	82	92	44	42	126	134	648	603
(c) Other	10	12	8	4	18	16	68	123
Nose or Throat	201	196	91	63	292	259	1,439	1,508
Speech	81	89	100	86	181	175	703	782
Lymphatic Glands	9	13	7	7	16	20	734	579
Heart	28	20	11	6	39	26	392	318
Lungs	129	116	29	18	158	134	589	604
Developmental :								
(a) Hernia	16	18	14	21	30	39	57	85
(b) Other	23	32	31	29	54	61	388	439
Orthopaedic :								
(a) Posture	6	6	7	8	13	14	142	161
(b) Feet	26	42	31	26	57	68	511	483
(c) Other	44	36	14	14	58	50	303	313
Nervous System :								
(a) Epilepsy	27	30	5	3	32	33	88	100
(b) Other	15	15	9	1	24	16	148	147
Psychological :								
(a) Development	12	24	29	13	41	37	796	799
(b) Stability	32	30	33	26	65	56	796	910
Abdomen	14	26	15	6	29	32	172	155
Other	24	33	8	5	32	38	226	268
Total no. of defects found	1,701	1,715	1,192	922	2,893	2,637	10,580	10,929
Percentage of total defects	58.80	65.08	41.20	34.97				

The county dental service 1972

Staff

The overall staffing position has shown only small changes in comparison with the previous year. The combined total of sessions worked by dental officers and dental auxiliaries amounted to 14,680 this year compared with 14,601 in 1971. At the close of the year 16 whole-time dental officers, 3 part-time salaried dental officers, and 27 sessional dental officers were in post with a whole-time equivalent of 26·6 officers, a similar figure to the 1971 staff total. Included in the total are 2 full-time and 2 part-time orthodontists with a full-time equivalent of 2·9 orthodontists. In addition, 6 whole-time auxiliaries and 1 sessional dental auxiliary were employed, whose whole-time equivalent was 6·2 in comparison with a whole-time equivalent of 7 dental auxiliaries for 1971. Dental officer staffing movements to and from the service have been less than average with 3 appointments and 2 resignations amongst salaried dental officers, together with 7 appointments and 9 resignations amongst sessional dental officers. Included in the 3 salaried posts was the appointment of an additional orthodontist carrying out 8 sessions per week. Dental auxiliary movements have however been above average with 4 full-time and 2 part-time resignations as opposed to 4 full-time and 1 part-time appointment.

Inspection and treatment

Treatment sessions carried out by dental officers this year increased by 512 but sessions undertaken by dental auxiliaries decreased by 433, the net gain being 79 sessions. Further progress is evident this year in the inspection programme when it proved possible to inspect 126,087 children, 86 per cent of whom were seen at school dental inspections. It is encouraging to report that the number of pupils inspected exceeded the previous year's total by 7 per cent and represents 70 per cent of the school population. With the combined total of treatment sessions carried out by dental officers and dental auxiliaries varying little from the previous year, only small differences of output are evident in the school dental service figures.

There were, however, increases in the number of children treated (higher by 638) and in the number of fillings in permanent teeth (higher by 2,123). A total of 4,409 permanent teeth were extracted, 1,595 of which were removed for orthodontic reasons, thus producing an overall ratio of 8·7 permanent teeth filled to each permanent tooth extracted (national figure 6·561) and an adjusted ratio, in which orthodontic extractions were excluded, of 13·6 to 1 (no national figures available). It is disappointing to report a reduction in the amount of work carried out for pre-school children. The number of these children inspected showed a reduction of 8 per cent compared with the previous year and the amount of treatment carried out for them was correspondingly lower. This is considered to be only a temporary setback in the number of pre-school children being brought to the dental clinics and it is hoped that mothers will respond to the advice being offered to them by health visitors and clinic doctors to seek dental inspection at an early age for their very young children.

Courses and conferences

Mr. Silver, one of the divisional dental officers, attended an extended part-time course in Dental Public Health and is to be congratulated in obtaining his D.D.P.H. at the conclusion of the course. One of the full-time orthodontists attended a one-week course on a specialized fixed appliance technique at the Royal Dental Hospital of London and also attended the annual meeting of the British Society for the Study of Orthodontics. A full-time dental auxiliary attended the two-day annual scientific meeting for dental auxiliaries held in London and another dental auxiliary attended a one-day in-service training course at Chelmsford. Training for National Health Service re-organization was instituted by the Department of Health and Social Security in the early part of

the year for persons working in the three branches of the National Health Service and courses were arranged at various centres throughout the country. The principal dental officer attended a multi-disciplinary 3-week course of this type on the Management of Integrated Health Care at York University in July.

Dental caries and enamel opacities survey

Fluoridation of the public water supply commenced in Watford in May 1956. In 1969 the Department of Health and Social Security published figures relating to the results achieved after 11 years of fluoridation in Watford. The figures indicated, over the combined age ranges of 8, 9, and 10-year-old children, i.e. those who had had the benefit of fluoridation for the whole of their lives, that the number of decayed permanent teeth fell by 50 per cent during the period of the study. In view of the fact that fluoridation has been in operation in Watford for more than 15 years it was considered desirable to record its effect on the permanent teeth of 12- and 14-year-old children. The survey, which was carried out by two of our divisional dental officers, investigated the caries experience, the proportion of sound mouths, enamel opacities, gingival health and habits relating to oral health in a fluoride area compared with a non-fluoride area. The aim of the study was to compare the levels of caries experience and enamel opacities in 12- and 14-year-old children from Watford and from a non-fluoride area in the South-West Division of the county. The investigation was conducted so that other variables such as age, sex, and oral hygiene standards were carefully excluded statistically, in a group of children of comparable socio-economic background. In order that school routine should be disturbed to the least extent, the survey was restricted to a single school in each area and was also combined with the annual school dental inspection. A total of 100 pupils were randomly selected from each school and of those selected from the fluoride area, it was ascertained that the children had lived in the area since infants school time but had not necessarily been born in the fluoride area. It must be stressed therefore that the figures obtained in this survey should not be compared directly with other studies, as the effect of immigration of young children from a non-fluoride area to a fluoride area will show the figures in a less favourable light than those obtained in investigations where fluoridation from birth is a criterion of the survey. In this study it was also decided to record the extent of the white flecks and striations on teeth (enamel opacities) which are present in some mouths in both artificially fluoridated areas and in non-fluoride areas and which some critics attribute to fluoridation. The figures relating to enamel opacities show the proportion of teeth with opacities and in the case of the 12-year-old group the examination for this assessment was restricted to the upper incisors and in the case of the 14-year-old group it was restricted to the upper incisors and canines. The survey produced the following figures:

	<i>12-year-old group</i>	
	<i>Fluoride area</i>	<i>Non-fluoride area</i>
Average age	12 years 11 months	12 years 11·9 months
Average no. of carious teeth per child (D.M.F.)	3·54	6·04
Enamel opacities	12·12%	9·14%
	<i>14-year-old group</i>	
	<i>Fluoride area</i>	<i>Non-fluoride area</i>
Average age	14 years 11 months	14 years 11 months
Average no. of carious teeth per child (D.M.F.)	5·17	8·51
Enamel opacities	6·97%	7·95%

The figures showing the extent of decay in the two groups are highly significant and demonstrate again the previously established findings from other countries that fluoridation of public water supplies produces a substantial reduction in the amount of dental caries and that this is continuous with the

increasing age of the child. A statistical analysis of the figure relating to enamel opacities indicates there is no significant difference between the proportion of teeth with enamel opacities in the fluoride area and the non-fluoride area.

The service and the future

This year has seen the commencement of the run up to the re-organization of the three branches of the Health Service. In July the decision was made known that the school dental service and maternity and child health dental service would be transferred to a unified National Health Service which would be administered locally by area health authorities whose boundaries would be coterminous with the new local authorities. One of the aims of reorganization is to bring about a high degree of co-operation between the existing branches of the health service with special regard for the health needs of the community as a whole. It is important to appreciate that dental care is a continuing process which is initiated with health education directed to the expectant and nursing mother and then continues from the pre-school child to the school child through to adulthood. If the community is to be provided with adequate dental care, then the fullest co-operation will be needed, not only for the treatment of the various age groups but also to ensure a satisfactory transfer of dental care from one branch of the service to another.

Table 37 Dental inspection and treatment, 1972

<i>School Dental Service.</i>				
Number of pupils on school registers (January, 1973)				181,094
(1) <i>Number of children inspected.</i>				
(a) At schools	.	.	.	108,519
(b) At clinics	.	.	.	17,568
(c) Re-inspection—school/clinic	.	.	.	9,562
Number of pupils requiring treatment (a) and (b)	.	.	.	56,941
Number of pupils requiring treatment (c)	.	.	.	5,412
Number of pupils offered treatment (a) and (b)	.	.	.	45,917
(2) <i>Visits (for treatment only)</i>				
	<i>Ages</i>	<i>Ages</i>	<i>Ages</i>	<i>Total.</i>
First visit—calendar year	5-9.	10-14.	15-over.	
Subsequent visits	13,966	11,617	2,516	28,099
	23,197	24,626	6,029	53,852
Totals	37,163	36,243	8,545	81,951
(3) <i>Courses of Treatment.</i>				
Additional courses commenced	2,389	1,377	247	4,013
Total courses commenced	16,355	12,994	2,763	32,112
Courses completed.	.	.	.	25,828
(4) <i>Treatment.</i>				
Fillings permanent teeth	12,656	25,922	7,812	46,390
Fillings deciduous teeth	22,122	2,158	—	24,280
Permanent teeth filled	9,973	21,738	6,866	38,577
Deciduous teeth filled	19,676	1,960	—	21,636
Permanent teeth extracted	387	3,214	808	4,409
Deciduous teeth extracted	9,698	3,463	—	13,161
General Anaesthetics	3,646	1,815	208	5,669
Emergencies	2,636	1,229	242	4,107
Number of pupils X-rayed	.	.	.	3,226
Prophylaxis	.	.	.	5,943
Teeth otherwise conserved	.	.	.	5,476
Teeth root filled	.	.	.	134
Inlays	.	.	.	5
Crowns	.	.	.	126
(5) <i>Orthodontics.</i>				
New cases commenced during year	.	.	.	642
Cases completed	.	.	.	483
Cases discontinued	.	.	.	104
Number of removable appliances fitted	.	.	.	1,019
Number of fixed appliances fitted	.	.	.	101
Number of pupils referred to hospital consultants	.	.	.	17

	Ages 5-9.	Ages 10-14.	Ages 15-over.	
(6) <i>Dentures.</i>				
Number of pupils fitted for the first time.				
(a) With full denture	—	—	—	—
(b) With other dentures	2	45	34	81
(c) Number of dentures supplied	2	45	36	83
(7) <i>Anaesthetics.</i>				
Administered by dental officers				2
(8) <i>Sessions.</i>				
	<i>Insp.</i>	<i>Treatment.</i>	<i>Dental Health Ed.</i>	<i>Total.</i>
Dental officers	914	10,093	12	11,019
Dental auxiliaries	—	2,003	94	2,097
Dental hygienists	—	—	—	—

Table 38 Dental services for expectant and nursing mothers and children under five years, 1972

<i>Attendances and Treatment.</i>		<i>Children 0-4 (incl.)</i>	<i>Expectant and Nursing Mothers.</i>
<i>Number of Visits for Treatment During Year.</i>			
First visit		1,897	159
Subsequent visits		3,192	314
Total visits		5,089	473
<i>Attendances and Treatment.</i>			
<i>Number of Visits for Treatment During Year.</i>			
Number of additional courses of treatment other than the first course commenced during year		241	8
Treatment provided during the year—number of fillings		4,724	381
Teeth filled		4,190	339
Teeth extracted		1,041	121
General anaesthetics given		514	10
Emergency visits by patients		268	25
Patients X-rayed		21	19
Patients treated by scaling and/or removal of stains from the teeth (Prophylaxis)		433	101
Teeth otherwise conserved		562	—
Teeth root filled		—	1
Inlays		—	—
Crowns		—	2
Number of courses of treatment completed during the year		1,754	113
<i>Prosthetics.</i>			
Patients supplied with F.U. or F.L. (first time)			6
Patients supplied with other dentures			15
Number of dentures supplied			28
<i>Inspections.</i>			
Number of patients given first inspections during year		3,871	235
Number of patients who required treatment		2,044	189
Number of patients who were offered treatment		2,027	189
Number of patients re-inspected		546	8
<i>Sessions.</i>			
Number of dental officer sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients.	For treatment		963
	For health education		3

School nursing service

Health visitors and the part-time state registered nurses employed to help them have assisted the medical officers at 4,296 medical inspection sessions. In addition, 1,807 pre-medical inspections have been carried out mainly by the state registered nurses. The nursing staff have examined 212,922 children at the routine personal hygiene sessions (see Table 54).

The Keystone Vision testing apparatus is in use throughout the county, and 75,556 children were tested. Additional routine work has been the nursing staff attendances at the 2,252 school clinic sessions. These clinics are mainly held for special examinations and the treatment of verrucae.

Health education in schools is somewhat sporadically carried out by health visitors and depends largely upon the wishes of the head teachers. Opportunities for teaching health subjects were taken up by health visitors on 540 occasions.

Ophthalmic and orthoptic service

Children are given routine vision tests at defined intervals throughout their school career. Those with defects can be either referred to a county council ophthalmic clinic or if the parents wish, obtain treatment under the General Ophthalmic Services of the Hertfordshire Executive Council through the family general practitioner.

Ophthalmic clinics

Medical staff employed by the regional hospital boards attend the authority's ophthalmic clinics, the statistics for which are set out in Table 39.

Table 39 Ophthalmic clinics, 1972

Centres	No. of Sessions	Attendances		No. of Refractions	No. of cases for whom spectacles were prescribed
		New	Rx.s		
<i>North Herts.</i>					
Hitchin . . .	36	195	470	193	90
Stevenage . . .	45	179	417	217	114
<i>East Herts.</i>					
Hertford . . .	63	111	356	446	158
Bishop's Stortford . .	35	125	338	262	105
Buntingford . . .	3	13	68	8	11
Cheshunt . . .	38	155	350	464	127
<i>Mid Herts.</i>					
Hatfield . . .	20	56	238	175	84
Welwyn Garden City .	45	170	500	293	176
<i>St. Albans.</i>					
St. Albans . . .	61	240	604	895	343
Harpenden . . .	30	185	320	472	172
Boreham Wood . .	37	123	230	172	100
<i>South-West Herts.</i>					
Watford . . .	155	574	791	1,351	410
Rickmansworth . .	18	65	92	152	45
<i>Dacorum.</i>					
Hemel Hempstead . .	121	298	923	1,020	304
Berkhampstead . .	4	10	19	34	6
Totals . . .	721	2,499	5,728	6,154	2,245

Although there continued to be a shortage of medical staff in this service, attendances showed a slight increase over 1971. Correspondingly there was an increase of nearly 200 in the number of children prescribed spectacles.

Orthoptic clinics

Six orthoptists were employed equivalent to 3.6 whole-time staff. They hold clinics at county health centres and treat children referred by consultant ophthalmologists. Clinic waiting lists have been kept to a minimum and by December 1972, waiting lists only existed in the Watford and Hemel Hempstead areas. Nearly all the children on the waiting lists were pre-school children as there was an increase of new cases referred in this age group.

The waiting lists for non-urgent hospital surgery has again been commented on by several of the orthoptists. With the opening of the Lister Hospital, Stevenage, it is hoped that the waiting time for surgery will be reduced during 1973.

Table 40 Orthoptic clinics, 1972

Clinic	Sessions	Attendances	No. of Children as at 31.12.72		Waiting List of new cases as at 31.12.72
			Under treatment	Under observation	
Stevenage . . .	110	603	47	90	—
Hitchin . . .	107	462	106	184	—
Cheshunt . . .	28	160	27	75	—
Ware	27	135	31	49	—
Hatfield . . .	46	431	39	95	—
Welwyn Garden City	141	1,200	89	268	—
St. Albans . . .	191	1,034	35	329	—
Watford/Oxhey .	462	2,922	36	40	9
Hemel Hempstead .	215	1,253	62	185	13
Totals	1,327	8,200	472	1,315	22

Audiometry

During the year three full-time and one part-time audiology technicians were in post. The two trainees completed the first part of their course and were able to undertake some of their practical training in Hertfordshire. With this additional help a special effort was made by the staff to bring the screening service in the North and East Divisions up-to-date. It is pleasing to note that this was achieved.

Over 22,500 children were screened during the year and just over 2,000 failed the screening test. These children are subsequently given an individual pure tone audiometric test. If the hearing defect is confirmed they are referred to a medical officer in department for examination and further action, as necessary.

Audiology

Audiology clinics are staffed by a Regional Hospital Board consultant audiologist (Dr. Bickerton) and a medical assistant. Seven weekly sessions are

arranged at health centres throughout the county and details of attendances, etc., are shown in Table 42.

Dr. M. V. Bickerton, Consultant Audiologist, reports that:—

“ There has been little change in the audiology services for the county of Hertfordshire during 1972. Audiology clinics are still held regularly at the six centres, there being seven sessions by an otologist available per week for this purpose.

Health visitors continue to carry out a screening test of the hearing of all children aged 6–9 months, and a speech test on older children brought to their notice as having a hearing difficulty. Children failing the screening test are referred by the health visitors to either a medical officer in department or the family general practitioner.

Three health visitor training courses were held during the year, to enable the health visitor to further understand the problems of the deaf child and its family, and also to learn of the screening hearing tests used in the county.”

All children provided with hearing aids are referred to the education department advisory teaching service and a report by the county adviser on deaf and partially hearing education, Mr. D. A. Grossman, follows:—

“ The numbers of children in the county at the end of 1972 with sufficient hearing impairment to require the use of hearing aids were as follows:—

- (a) Pre-school children (41).
South-West Herts 7, Dacorum 7, Mid Herts 7, North 6, Stevenage 0, East 5, St. Albans 9.
- (b) Children in special schools other than those primarily intended for the hearing handicapped (38).
South-West 12, Dacorum 2, Mid Herts 1, North 2, Stevenage 3, East 6, St. Albans 6, Sub-Normality Hospitals 6.
- (c) Children in partially hearing units (82).
- (d) County children in schools for the partially hearing, mostly Tewin Water School (22).
- (e) Children in nursery/infant unit for deaf children at Lonsdale School (10).
Children at out-county schools for the deaf (80).
- (f) Total number of children in county sufficiently hearing impaired to require hearing aids (422).

In addition to the children listed above in (a) and (b) there was a comparatively large and varying number of children with defective hearing who did not need hearing aids but require occasional sessions of the advisory teacher's time. Typical of these are children with variable conductive losses or unilateral deafness due to mumps.

Table 41 Children in normal schools

Division	Infants	Junior	Secondary	Private	Total
South-West .	1	14	14	2	31
Dacorum . .	4	7	8	0	19
Mid Herts . .	4	6	9	2	21
North . . .	1	4	7	3	15
Stevenage . .	2	3	2	0	7
East	1	6	20	1	28
St. Albans . .	2	11	15	0	28
	15	51	75	8	149

Table 42 Audiology clinics, 1972

CLINICS													
	Hatfield		Hemel Hempstead		Hitchin		Watford		St. Albans		Hoddesdon		Totals
	School children	Others	School children	Others	School children	Others	School children	Others	School children	Others	School children	Others	
No. of sessions	46		61		57		45		56		29		294
Attendances—													School children and Others
New cases	39	41	61	60	34	53	46	33	40	37	28	31	503
Re-examinations	111	33	185	46	116	63	115	37	145	57	109	21	1,038
Total	150	74	246	106	150	116	161	70	185	94	137	52	1,541
Number of new cases reported as having—													
Normal hearing	17	24	28	45	15	34	18	26	19	23	9	24	282
Impaired hearing	18	9	25	8	15	6	21	6	12	3	13	2	138
Partial hearing	1	2	3	—	3	5	4	1	8	3	2	2	34
Severe deafness	—	—	1	2	—	2	1	—	1	1	1	1	10
Degree of hearing not yet known	3	6	4	5	1	6	2	—	—	7	3	2	39
Recommendations—													
Discharged	30	29	63	40	43	28	33	25	40	26	31	21	409
For follow-up appointments	120	45	183	66	105	88	128	45	145	68	105	31	1,129
Referred ? Surgery	—	—	7	2	11	5	8	2	8	4	7	6	60
No. of hearing aids issued during year	2	3	10	1	4	2	8	2	8	7	6	1	54
Cases waiting first examination appointment	15		—		33		39		35		19		141

Table 43 Audiometry testing, 1972

(1) <i>Screen Testing :</i>							
(a)	No. of sessions	.	.	.	.	.	499
(b)	Schools visited	.	.	.	.	.	341
(c)	Pupils tested	.	.	.	.	.	22,509
(d)	No. of children—normal hearing	.	.	.	.	.	20,483
(e)	No. of children—failed test	.	.	.	.	.	2,026
(2) <i>Individual Audiometric Testing :</i>							
(a)	No. of sessions	.	.	.	.	.	590
(b)	Children tested—(Screen Test Failed)	.	.	.	.	.	1,865
(c)	Children tested—(Referred by M.O.s)	.	.	.	.	.	2,709
(d)	Children found to have hearing within normal limits	.	.	.	.	.	1,881
(e)	Children reported for further investigation	.	.	.	.	.	2,093
(f)	Children awaiting testing	.	.	.	.	.	60
(3) <i>Audiology Clinics :</i>							
(a)	No. of sessions	.	.	.	.	.	294
(b)	Children tested	.	.	.	.	.	1,373
(c)	Ear moulds prepared for hearing aids	.	.	.	.	.	565

Pre-school children

Work with pre-school hearing handicapped children and guidance of their parents has continued as before. A residential course for some of the parents was held at Balls Park College in April. To enable fathers of these children to take a more effective part in helping them, a successful evening discussion group was arranged. Co-operation with the social workers for the deaf in work with families with deaf infants has been much appreciated by the advisory teachers of the deaf.

Partially hearing units

There are now 10 such units in the county including infant, junior, and secondary ones. The advantages the children who attend them gain are very much the product of the skill of their specialist teachers and the results of the co-operation and enthusiasm of the head teachers and other members of the staffs of the schools, of which the units are part.

As in previous years, conferences for the heads of these schools and the unit teachers have proved very valuable as means of exchanging ideas and information. A course for the welfare assistants in the primary units was held. They play a vital role in this kind of work.

Children with hearing aids in normal schools or special schools other than those for hearing handicapped children

Regular help for all these children and guidance of their teachers have been maintained by the advisory teachers of the deaf. One-day courses have been made available at teachers' centres.

A four-day course was held at Wall Hall College for those concerned with the communication problems of multi-handicapped children.

Children in schools for the deaf

Until September of this year, all deaf children in Hertfordshire attended schools outside the County. Anticipating the opening of a new primary school for them in St. Albans early in 1975, a nursery class of deaf children was started at Lonsdale School in September. They, together with another class to be started in September 1973, will form part of the nucleus of the new school for the deaf.

Courses

In addition to the courses mentioned above, the advisory teachers of the deaf have been involved in courses for medical officers, teachers, nursery nurses, parents, health visitors, students, etc.

Audiology clinics

Close co-operation has continued to be maintained with the county's consultant audiologist and her staff, both in work with individual children and in the provision of some of the courses mentioned above."

Speech therapy

It is with very deep regret that I record the untimely death in July 1972, of the County Senior Speech Therapist Mr. Leonard Willmore, F.C.S.T., who had been in the service of the county council for 26 years. Mrs. Margaret Evesham was appointed as his successor and will, it is hoped, be joined by a second senior therapist during 1973.

Services for children with speech defects

1. The origins and development of speech therapy

As early as the beginning of the century a few self-styled "specialists" advertised their claims to cure speech defects—particularly stammering. In many cases they were quite mistaken or ignorant of the true nature of these conditions and as a result treatment was ineffective or even harmful. Before the first world war, however, a small number of local authorities had appointed teachers of elocution to deal with children with defective speech. Subsequently it was realized that in view of the serious handicap of speech and language disorders, more adequate provision would have to be made.

A further impetus was given during the second world war because of the need for specially trained staff to deal with severe speech defects due to war injury. Concurrently more requests were coming from education authorities who were becoming increasingly aware of the contribution speech therapists could make to the health and education of the school child.

At this time there was no single recognized qualification for speech therapists. There were four small training schools in England each having its own syllabus and examination. In 1945 the present College of Speech Therapists was founded as an administrative and examining body to provide a common syllabus and examination for all students. The three-year course is medically based and independent of existing courses in speech training and dramatic art. The entry requirements are a minimum of five G.C.E. subjects two at "A" level.

The Diploma of the College is now the sole channel of entry to the profession and admission to the National Register of Qualified Speech Therapists.

The course comprises study and examination in anatomy and physiology, phonetics, psychology, neurology, speech pathology and therapeutics, and a comprehensive study of all aspects of human communications. Lectures and visits are included to give a working knowledge of the physics of sound, psycholinguistics, diseases of ear, nose and throat, plastic surgery, orthodontics, the social services and special schools for physically and mentally handicapped children. All students have clinical experience, and work under supervision with child and adult patients in hospitals and health centres. Success in the final theoretical and practical examinations entitles the candidate to be registered as Licentiate of the College of Speech Therapists. In addition to this Diploma course, a university degree course has been established which qualifies graduates to become Licentiates of the College and to obtain posts as speech therapists or research workers in the field of disorders of human communication. Many universities accept either of these qualifications as entry to a post graduate degree course.

The speech therapists treat children who have difficulty in expressing themselves in spoken language either because they do not fully understand and retain words and sentences and therefore cannot reproduce them, or because of an inability to articulate the complex sequences of speech sounds which are

required to make speech intelligible. The kinds of disorders met with can be categorized under a number of headings:

- (a) *Delayed or disordered speech and language development.* The severity of these cases varies widely from the persistence of infantile speech to severe speech and language problems requiring prolonged treatment.
- (b) *Cleft palate or other structural deformity* often gives rise to speech defects which require prolonged treatment.
- (c) *Neurological defects*, cerebral palsy (spasticity) and other forms of brain damage often involve severe defects of voice, speech, and language.
- (d) *Stammering.* A great deal of research into this condition has been carried out in this and other countries, and new methods of treatment are being developed which are proving to be quite successful.

Young children with any degree of delayed speech development or abnormality are referred to the speech therapists by medical officers, general practitioners, and hospital consultants for assessment and opinion, the doctor having first investigated any medical conditions which may be contributing to the speech difficulty. The health visitor plays an important role in the detection of abnormalities of speech as a result of her regular supervision of the health of the pre-school child. She would normally refer any child about whose speech she was concerned to the medical officer or general practitioner in the first instance.

The speech therapist has first to obtain from the parent detailed information of all stages of the child's speech development. From a detailed analysis of the child's problem and study of the medical and psychological factors, the speech therapist decides on a course of treatment. In the more difficult cases she maintains close liaison with medical staff, psychologists, psychiatrists and teachers. The therapy carried out by speech therapists is usually given individually for half-hour periods once or twice a week. Much of this is disguised in the form of games and competitive activities to stimulate auditory attention, neuro-muscular training, vocabulary, and memory span, plus language development while at the same time retaining the child's cooperation and interest. This is by no means easy with a highly distractable or hyper-active child. Parent counselling in suitable cases plays an important part in treatment. When treating school children the therapist is in close contact with members of the teaching staff. Speech therapists hold regular speech clinics in health centres throughout the county. Where numbers justify it and accommodation is available speech therapists also hold regular therapy sessions at schools.

Prior to 1969 children who had very serious speech defects requiring intensive speech therapy and special education were sometimes placed in special residential schools. Because of the increasing understanding of the medical, educational, and communication problems posed by these children, the number of children who are felt to be likely to benefit from intensive speech therapy has increased and in 1969 units were set up for about 12 infant school children in Hemel Hempstead and in Stevenage. Each unit is staffed by a full-time teacher, a speech therapist and a welfare assistant, and the children are transported from surrounding areas. Similar units for children from 7 to 11 years were established in 1971 also in Hemel Hempstead and Stevenage. All these units have proved to be very successful for the severe cases which need intensive special education and speech therapy and usually it is no longer necessary to place these children in special residential schools. The effects of increased knowledge in this field are also being felt in the education of physically handicapped, E.S.N. and mentally handicapped children, and the heads of special schools are pressing for an increase in the allocation of speech therapists' time. Still further demands on the speech therapy services are anticipated as the work of the assessment units in E.S.N. schools increases.

All the authority's speech therapists are women, many of whom work on a sessional or part-time basis. As an incentive to married therapists with children, arrangements have been made for them to work clinic sessions during school hours in term time.

Following a review of the county speech therapy service the Education Committee approved a phased increase of the establishment of therapists from 18 to 25 by March, 1973. This establishment is equivalent to one speech therapist per 7,500 school children.

In July 1969 the government appointed a committee of enquiry into speech therapy services. Their report was published at the end of 1972. Included in the committee's recommendations were the following:

- (i) That the service and career structure be reorganized within the Health Service.
- (ii) All future training of speech therapists should be at degree level.
- (iii) Everything possible should be done to increase the numbers of speech therapists from the present equivalent of 800 full-time practising therapists to 3,500.

The committee made special mention of the steps which had been taken by Hertfordshire to encourage married therapists to return to the profession.

Table 44 Speech therapy clinics, 1972

Clinics	Sessions	No. of children treated	Total attendances	No. of children as at 31.12.72		Waiting list of new cases as at 31.12.72
				Under treatment	Under observation	
<i>North Herts.</i>						
Letchworth . . .	114	20	588	13	18	2
Stevenage . . .	255	66	1,233	23	118	40
Hitchin . . .	291	72	1,054	39	54	6
Royston . . .	64	10	292	8	7	1
<i>St. Albans.</i>						
St. Albans . . .	381	213	1,739	92	127	15
Harpenden . . .	193	115	914	22	54	4
Boreham Wood . .	222	69	837	35	33	3
<i>Dacorum.</i>						
Hemel Hempstead .	614	267	3,154	55	112	17
Berkhamsted/Tring .	258	84	713	23	44	8
<i>Mid Herts.</i>						
Hatfield . . .	157	37	680	22	15	21
Welwyn Garden City	312	182	1,667	53	80	10
Potters Bar . . .	82	24	378	12	12	10
<i>East Herts.</i>						
Cheshunt/Waltham X.	154	124	1,100	69	38	6
Hoddesdon . . .	162	141	760	22	44	—
Ware . . .	258	106	1,730	22	43	3
Bishop's Stortford .	110	91	445	—	—	—
Hertford . . .	120	32	552	14	44	11
Buntingford . . .	43	12	171	*3	14	3
<i>South-West Herts.</i>						
Watford . . .	642	258	2,814	94	75	30
Rickmansworth . .	112	60	664	13	6	45
Oxhey . . .	398	94	1,864	44	49	3
Totals . . .	4,942	2,017	23,369	678	995	238

Handicapped children

During 1972 a total of 484 new cases were assessed by medical officers as requiring special education. At the end of the year 3,153 children were receiving special educational treatment and arrangements had been made for a further 111 children on waiting lists to be admitted to special schools early in 1973.

Forty-three previously registered handicapped children moved with their families into the county during the year. They were transferred to Hertfordshire county council schools if this was appropriate or alternatively with the authorities' approval remained at their previous special schools.

The facilities provided by the Education Department for the special educational treatment of handicapped children are becoming increasingly sophisticated and comprehensive and I am indebted to the county education officer for permission to reproduce his report to the Special Services Sub-Committee on the subject of the education of handicapped children.

The education of handicapped children

Special education is at a somewhat confusing stage at the present time, perhaps particularly in Hertfordshire, but to almost as great an extent throughout the country. In this county, because of the opening of new schools planned several years ago and the transfer to the Education Committee of the six former junior training centres and the schools at three hospitals, the number of special schools was doubled in a single year from 14 to 28. This situation has, of course, caused difficulties but has in effect only concentrated over a short period problems which would in any case be inevitable in a growing county and a developing service.

What is perhaps more interesting is the growing complexity and sophistication of the service. It is not so many years since the choice for a handicapped child lay between going to a boarding special school or staying where he was. Now the range of choices is far more elaborate and their very complexity makes much greater demands on all the people concerned with children who have special problems of some kind.

There are still children who must be sent to boarding schools a considerable distance from their homes—for example, a blind child whose parents wish him to attend a Roman Catholic school, a deaf child who wants an academic education or an emotionally disturbed boy for whom it has not been possible to find a vacancy in one of our own schools. For some handicapped children, boarding school may well be the most appropriate place but there is a growing awareness of the disadvantages of sending a child to a school a long way from his home.

Many handicapped children attend day special schools. There are now in Hertfordshire 17 day or day and boarding schools for slow learning and mentally handicapped boys and girls, most of them taking a considerable number of multi-handicapped children. Four of the five residential schools for the maladjusted also take day pupils as do the boarding schools for the partially hearing and the physically handicapped.

There is a wide variety of schools in London and the north London boroughs which Hertfordshire children can attend daily. Increasingly heavy traffic is adding to the difficulty of making suitable road transport arrangements for these children but even so it is clear that the network of day special schools for children with a wide variety of handicaps is making it possible for many children to receive the extra care and the special type of education they require while still living at home and remaining a part of their own neighbourhood.

Special classes attached to primary and in some cases to secondary schools have been set up throughout the county. There are now 23 groups for emotionally disturbed children, 9 partially hearing units and 4 classes for speech-handicapped children. During the next few months it is hoped to experiment

with the admission of one or two visually handicapped children to units for naturally hearing children.

Qualified teachers who are not attached to specific schools are playing a valuable part in the service for handicapped children, both those with permanent and serious handicaps like partial deafness and also the children who may for a variety of physical and emotional reasons have found themselves unable to benefit from normal education, often through difficulty in reading. There are now in the county 6 teachers of hearing handicapped children who work both with very young children and their mothers at home, and with older boys and girls who with regular help from visiting teachers can get on satisfactorily in the normal school. For the children with reading difficulties, there are at present 14 specialist teachers, 2 in each division, who work in close conjunction with the educational psychologists and visit children in their own schools. All are faced with growing waiting lists and provision is being made in the revenue estimate for 1972-73 for 2 additional teachers to be appointed from September 1972.

In addition to the specially qualified staff, part-time teachers may be asked to give special help for a limited time to a child who for one reason or another has fallen badly behind and is unable to enjoy or benefit from his education without special help. In a few cases, particularly where physically handicapped children are concerned a welfare helper may be employed to be specially responsible for one child and this may make it possible to keep a child in the ordinary school when he and his parents are anxious for him to stay in the general stream of education instead of going to a special school. This arrangement may be extremely valuable but it is important to realize that a special school with all its facilities, qualified staff and knowledge of the available provisions may be, in the long term, more suitable than a primary or secondary school where the child is to some extent isolated among people with necessarily limited resources for helping him.

The education services available for the handicapped have been very briefly summarized in this report. The tendency towards greater complexity seems to be having two immediate results—the special schools themselves, both day and boarding, are coming under much greater pressures and the proper use of the many facilities that are available demands greater skill and experience on the part of everyone concerned with the child and his family.

So far as the schools are concerned, severely handicapped and multi-handicapped children must be accepted and having been taken into the schools they must be helped. The straightforward dull child or child with one clear-cut handicap forms only a small proportion of the special school population. As doctors and teachers learn more about ways of helping children so greater demands are made on them, and inevitably this involves extra accommodation, extra equipment and above all extra staff. This, of course, shows in the running costs of the school, particularly perhaps the schools for the mentally handicapped with their high proportion of severely and multi-handicapped children.

The child's own problem is a combination of social, physical and psychological factors and his needs may change within quite a short period. He may have been involved with a variety of people, doctors and consultants, social workers, psychologists, and teachers. It is important that everyone concerned with him has some understanding of the facilities available and it is often at this stage that the educational psychologist with his double role in the medical and educational world is most valuable. A complicated and sophisticated service makes great demands on everyone concerned, perhaps not least on the parents, who more than ever before need to be able to discuss their child and the many alternative ways of helping him with someone able to understand both their anxieties and the facilities that are available. The demands made on doctors, psychologists, social workers and teachers are far greater than in the days when the choice lay between sending a child to a boarding school and leaving him where he was.

Table 46 Handicapped children (as at 25.1.73) receiving special educational treatment

Category	Hertfordshire County						Non-Hertfordshire					
	Special Schools		Units	Classes	At home	Hosp. schools	Total	Schools		Units	Hosp. schools	Total
	Day	Res						Day	Res			
Blind	—	—	—	—	—	—	—	1	18	—	—	19
Partially sighted	—	—	—	—	—	—	—	16	12	—	—	28
Deaf	—	—	10	—	—	—	10	6	74	—	—	80
Partially hearing	5	15	80	—	—	—	100	—	2	2	—	4
Physically handicapped	113	11	—	—	5	—	129	14	44	11	7	76
Delicate	—	—	—	—	—	—	—	4	40	—	—	44
Maladjusted	51	169	—	217	71	—	508	8	161	—	17	186
E.S.N.	1,656	97	—	—	3	55	1,811	9	67	—	27	103
Epileptic	—	—	—	—	1	—	1	—	13	—	—	13
Speech	—	—	—	40	—	—	40	—	1	—	—	1
Totals	1,825	292	90	257	80	55	2,599	58	432	13	51	551
												3,153

Table 47 Handicapped pupils—Special classes and units

Unit or Class	No. of	Number of Children in Attendance as at 25.1.73						
		Steven- age and North	East	South West	Mid	Dacorum	St. Albans	Totals.
Partially hearing .	9	20	19	15	—	—	26	80
Deaf . . .	1	10	—	—	—	—	—	10
Emotionally disturbed and retarded . .	29	76	29	32	41	17	22	217
Speech defective .	4	23	—	—	—	17	—	40
Totals . . .	43	129	48	47	41	34	48	347

Table 48 Handicapped pupils attending ordinary schools

Category	Boys	Girls	Total
Partially sighted . . .	9	11	20
Partially hearing . . .	86	75	161
Epileptic	13	14	27
Delicate	28	17	45
Physically handicapped .	153	151	304
Totals	289	268	557

Child and family psychiatric service

The child and family psychiatric service again had a somewhat difficult year. There were numerous changes in staff and continuing difficulty was experienced in filling vacancies for medical and psychotherapist posts. The accommodation problems remained unresolved at St. Albans, Hemel Hempstead, Hitchin, and Bishop's Stortford clinics but it is hoped that alternative accommodation will be available at Hitchin and Bishop's Stortford during 1973. At Hemel Hempstead despite repeated efforts to obtain a large house no success was achieved, whereas at St. Albans it is expected that accommodation for the child and family psychiatric clinic will be made available in the new health centre when this is built. This is however a long-term solution.

Having mentioned the problems I must emphasize the invaluable contribution the staff make in resolving the more serious emotional problems suffered by children and their families. As a result of the changing pattern of work in the child guidance service, mention of which is made in several of the directors' reports, it has become increasingly apparent that the present statistics relating to this service do not give an adequate picture of the work undertaken by the staff. Further thought will have to be given to this matter during 1973.

Dr. Roper, Consultant Psychiatrist Hitchin and Stevenage Child and Family Psychiatric Clinics reports:—

“The year 1972 has been a difficult one for both clinics. This has been caused by the uncertainty which inevitably results from staff changes. If the

clinic is to function properly it is essential that the three disciplines, that of psychiatrist, psychologist, and social worker should work closely together and communicate freely with each other. Changes of personnel inevitably disrupt this process and it takes time to build up a fresh team approach.

The opening of the new Lister Hospital in September, 1972, was in my opinion the most important event in 1972 for this part of the county. The psychiatric department of 75 beds has no provision for children or adolescents, but because the child psychiatrist has an appointment at the hospital there is an opportunity to influence future policy, to maintain close contact with the psychiatrists in the adult unit and also with the paediatricians and other departments of the hospital. I would see this as being the bridge between the hospital service and the community service, the missing link only being an appointment with the Social Services Department, a development which I would hope will come in the future.

I first came to work in Hertfordshire in 1956—since when I have worked in every clinic in the county except two. I would like to end my last annual report by thanking the county council and all its officers for the help I have received from them in our mutual care and concern for children. Whenever I have asked for help for any of my patients, it has been forthcoming both from the Health Department and the Education Department, and this is particularly true of special education where they have done their utmost to accede to my requests.”

Dr. Berstock, Consultant Psychiatrist St. Albans, Boreham Wood, and Potters Bar Child and Family Psychiatric Clinics reports:—

St. Albans and Boreham Wood clinics have during the past year continued as a training centre for psychiatric registrars and student social workers on both long and short term placements, mainly from the Hatfield Polytechnic.

In comparing the annual figures with last year, there has been an increase in referrals but the waiting list has continued to be at a minimum. Changes in diagnostic procedure have gradually crystallized and we now aim at at least one initial joint family meeting. Although we adopt flexibility according to the individual problem, the family meetings offer valuable means to view the degree of inter-play between the internalized disturbance and family dynamics. We continue to extend our contacts outside the clinic and during the year a number of meetings have been arranged in schools to discuss individual problems and difficulties with the teachers. A number of introductory discussion groups on child psychiatry have been given to the Shenley nurses and priests and we continue to have a fortnightly clinical meeting when visitors from the Social Services Department, school medical officers, etc., have been invited.

In thinking of our future objectives we would hope that our multi-discipline team—psychiatrists, psychotherapists, psychologists, social workers—can become a meaningful part of the medical and social specialities so that we can share, communicate, and learn from each other and therefore continue to offer an important, comprehensive, psychotherapeutic treatment to the disturbed child and the disturbed family.

The inadequate accommodation which has been repeatedly reported continues to present increasing difficulties.

Dr. McGlashan, Medical Director Watford Child and Family Psychiatric Clinic reports:—

The imminent changes in the National Health Service following on the changes in the Social Services Department brought about by the implementation of the Seeborn Committee's recommendations have prompted us to do a lot of serious thinking about our function in the community.

As a first step to having a closer look at just how the community sees us currently, we had an Open Day in the early summer. We invited all family doctors and head teachers to a one-day conference. We hoped that not only

would our referring agents learn something about the way we currently see our work but that perhaps suggestions might come from them as to new projects.

One such project has already got under way as a result of the Open Day. Mrs. Shipley, social worker, and a general practitioner have started, in the latter's practice, a series of group meetings with mothers who share problems over baby management. This meets a local need and at the same time may well prevent later referral.

As the clinic has got better known we are increasingly asked by various agencies in the community to give talks on a variety of subjects. This year Mrs. Hearst, senior case worker, gave a paper on "Family Psychiatry—Links with schools", at a teachers' day conference. Dr. Enfield, senior registrar, has, with other members of the clinic staff, met student teachers to tell them about the clinic, and Dr. Enfield has also had a series of meetings with a group of teachers at the teachers' centre to discuss problems arising in schools. Mr. Reeves, psychotherapist, has led discussions at a series of presentations of films on the effects of separation and hospitalization.

Another new development which has taken place is the involvement of the clinic in the new General Practitioner Training Scheme. Doctors intending to specialize in general practice will have a two years' training course where not only will they be attached to a practice but will have a series of rotating six months posts in relevant specialities. One such speciality is psychiatry and it is envisaged that the trainees will spend one day attached to the child and family psychiatric clinic. Although the trainees have not yet reached this stage in their two-year course, we have in any case taken on two young assistant G.P.s for short placements. They have been able to see something of the work of the clinic, go on home visits with social workers, and observe diagnostic assessments.

With the opening of the new District General Psychiatric Unit in Shrodells, it has seemed important to try and work as closely as possible with the staff there. We have always had informal links with Heathdene Day Hospital but it now seems even more important that all agencies aiming to offer support to whole families should work closely together. It would be all too easy to have wasteful overlap when there are three separate psychiatric units in the same community all aiming to work closely with families, apart from the work carried out by the Social Services Department and Probation Service. We have had various meetings with medical staff in the adult department to try and find practical ways of collaborating.

Mrs. Hearst, senior case worker, is now training at the Institute of Group Analysis in London and we hope that this will lead to a further extension of the services which we can offer locally.

We have been able to extend the sort of crisis consultations which we offer to other caring agencies.

This year for the first time I have had a regular weekly session in the Peace Memorial Hospital Out-Patients' Department, seeing children referred by the hospital consultants, in addition to continuing to see on demand in-patients in the children's wards. This has made for closer contact in particular with the junior paediatric staff.

As we had hoped it has proved most helpful to have two registrars who are placed part-time in the clinic and part-time in the Tavistock and has, I think, been stimulating on both sides.

An increase in the numbers of clinical staff in the clinic has meant that we have been able to increase the variety of treatment programmes offered to patients. Two of the psychologists have run groups in the clinic for young children. There has been an increase in group work with parents and there has also been a marked increase in the number of family interviews as one of the registrars in particular has been interested in developing this technique.

As usual we have had students on various social work training courses placed with us for varying periods. Student nurses from Napsbury Mental Hospital have also visited the clinic as part of their training.

At the same time as extending the range of treatment programmes which we can offer to the community we are, therefore, doing more primary preventive work and taking an increasing part in medical and social work training.

We hope that by extending our interests and skills in the ways outlined above we shall have an increasingly useful part to play, however the child and family psychiatric services may develop after 1974.

Dr. McGlashan, Medical Director Hemel Hempstead Child and Family Psychiatric Clinic reports:—

“ Work in the child and family psychiatric service in Hemel Hempstead has been severely hampered in 1972 by accommodation and staff shortages. In spite of this, largely owing to goodwill on the part of members of staff, the work has continued to develop.

Because we are well known locally increasing demands are made on us and in particular we have become aware of a need for a consultation service to the local children's homes. On our present psychiatric staffing establishment we cannot add this service to the other services which we provide, but I certainly feel it is something very valuable and I would be very interested in developing this. For the time being our psycho-therapist, is hoping to offer some consultation time.

We have been increasing the amount of work done with whole families, not necessarily at the clinic. This means that clinic figures for children seen and treated at the clinic do not necessarily reflect the work done with children referred to the clinic. Some families may be dealt with entirely at home and unless the system of returns is altered these referrals will only appear as ‘ social worker interviews ’. Perhaps this is something which could be looked at.

I have just written to a G.P. for example, telling him that our senior social worker has visited a family at home on several occasions. As a result the child whom he referred as a severe case of school refusal is now happily back at school. I myself have never seen this child and therefore from the point of view of the clinic returns he will not appear as someone who has been treated.

Many referrals are now dealt with by consultation with the referring agency so that the child is never seen here. Again this is a clinical use of psychiatric time in that a child is being treated, even if indirectly. Once again, the figures requested do not reflect this work.

It will be seen therefore that in spite of practical difficulties the work in the clinic has continued to grow and develop and there are indications it will continue to branch out in new and interesting directions in the coming year.”

Dr. Waldman, Consultant Psychiatrist Hoddesdon Child and Family Psychiatric Clinic reports:—

“ Much of the clinic functioning during 1972 was overshadowed by our shortage of a social worker, which seriously hampered referrals being dealt with as promptly as we like to.

The tutorial unit for phobic and other disturbed children continued to provide a valuable service, hampered as previously by difficulty in finding appropriate placements for children ready to leave the unit.

Our practice of going out to schools for consultative work has grown, and from our point of view has been found to be of particular value—I hope the schools feel the same way.

The medical directors have been agonizing about the shape of the new service. Our position in East Herts is particularly ambiguous having regard to our links with establishments in Essex such as the hospital at Harlow, making for planning difficulties.”

Dr. Anderson, Consultant Psychiatrist Welwyn Garden City Child and Family Psychiatric Clinic reports:—

“ The major change occurring at this clinic was its move from the Gooseacre to the Parkway Health Centre. Although the clinic staff missed the contacts that had been made over the years with the other professional workers using Gooseacre Health Centre, we have been made very welcome in our new premises.

The clinic continues to receive many referrals of children under five years. As I believe very much in prevention of mental illness, these children are being given priority in therapy. This does not mean that the psychotherapist does not treat children over five, but it does mean that these children, given early treatment, can benefit before being exposed to the additional stresses imposed by the wider community they encounter at school. Many have young mothers who have younger children or the prospect of increasing their family. In addition to the treatment, the child benefits from the experience the mother gains through her contact with the psychiatric social worker. I feel this is a very important aspect of work at the clinic.”

Dr. Anderson, Consultant Psychiatrist Hatfield Child and Family Psychiatric Clinic reports:—

“ Major staff changes during the year inevitably had their effect on the working of the clinic. For some months we were without social work help at all. Some of the families previously receiving case work support had made sufficient progress to be discharged. Those remaining were referred to different community agencies—chiefly the Director of Social Services for continued social work help. The two groups for which the social worker was involved—boys’ activity group and a mothers’ group had to come to an end. The number of referrals in 1972 was very slight, 10 only. I have no explanation for this but can only suggest that as community agencies knew we were without social work help they might have made alternative arrangements.

Twelve cases were referred to the clinic from the School Psychological Service and we, in turn, asked the educational psychologist to do psychological assessments of 29 cases.”

School psychological service

Miss E. M. John, senior educational psychologist:—

During the year the pattern of steady development of the School Psychological Service was implemented. The staffing was increased by an extra educational psychologist and two more remedial teachers. Within the schools two more special classes were opened. It became possible to see an increased number of children and to give practical help to more of them, but, notwithstanding these increases, the level of the waiting lists remained high and the service continued to operate under pressure.

Increasingly the educational psychologists help with the severely sub-normal children. The value of individual psychological assessments for this group of children is controversial and psychologists are aiming at spending more time seeing the children in their classrooms and discussing them with the teachers.

Now that there are more staff the psychologists are able to help more actively in in-service training. In May there was a two-day course at Offley on the Slow Learner at the Secondary School and this was well attended. More support has been offered by the psychologists to remedial teachers including those working at the secondary level. Starting in 1972 and extending throughout the ensuing academic year there have been courses at each teachers’ centre, where the local psychologists and remedial teachers have held a series of seminars on this topic. These local courses have been linked to two duplicated

courses at Offley Place. The raising of the school leaving age precipitated extra interest in this subject, and through these courses, many teachers were helped to deal more effectively with backward children.

Table 50 School psychological service figures for the year ending 31st December, 1972

	<i>East Herts</i>	<i>S.W. Herts</i>	<i>St. Albans</i>	<i>Mid. Herts</i>	<i>Stevenage</i>	<i>North Herts</i>	<i>Dacorum</i>	<i>Totals</i>
Interviews with children:								
Clinic	52	178	65	168	74	75	111	723
S.P.S.	447	439	374	497	280	157	347	2,541
Interviews with parents	259	415	276	388	226	135	276	1,975
Professional consultations	310	747	679	1,258	106	552	432	4,084
School consultations	389	980	351	613	203	345	314	3,195
Lectures, seminars, discussion groups	37	271	47	78	29	30	90	582
New cases seen S.P.S.	243	216	188	230	161	292	140	1,470
New cases referred S.P.S.	207	238	207	257	235	194	163	1,501
Waiting list	28	44	50	144	63	37	48	414
Units in area	4	4	3	6	5	7	4	33
Children in units	43	32	33	41	47	32	34	262
Children under remedial teaching	56	75	42	63	56	16	76	384
Boarding school visits	7	16	2	13		1	6	45

Recuperative holiday home care

The Authority continued to provide recuperative holidays for school children recommended by medical officers in department, general practitioners, social workers, etc. During 1972 twenty-two children were placed at holiday homes for periods varying from 2–6 weeks. The children concerned were in the main requiring short term holiday home care because of general debility and asthmatic conditions. Diabetic cases were provided with a holiday at one of the Diabetic Association camps. Special holiday arrangements were also made for several deprived handicapped children who parents were unable to adequately care for them during school holidays because of the severity of their physical handicaps and difficult home circumstances.

Other medical examinations

1. Entrants to teacher colleges of education

Local education authorities are required to arrange for the medical examination of :—

- (a) College of education candidates resident in their areas, and
- (b) persons entering the authority's employment as teachers, who had not taken a course under the Training of Teacher's Regulations, and have not received a medical examination.

During 1972, the school medical officers examined 1,255 college of education candidates and 221 teachers in category (b). College of education candidates are advised to have a chest X-ray before entering college. At the finish of their training they are also medically examined by the college medical officer and X-rayed.

2. Employment of children bye-laws

Children in employment out of school hours come within the scope of these bye-laws and should be medically examined before starting work. In 1972, 2,032 pupils were examined, none were reported to be unfit to undertake the employment proposed.

Statistical tables for the whole county

Medical inspection and treatment, 1972

The official return to the Department of Education and Science for the year ended 31st December, 1972 was as follows :—

Number of pupils on registers of maintained Primary and Secondary Schools (including Nursery and Special Schools) in January, 1973 181,094

Part I.—Medical inspection of pupils attending maintained primary and secondary schools (including nursery and special schools)

Table 51 Periodic medical inspections

Age Groups Inspected (by year of birth)	No. of Pupils Inspected	Physical Condition of Pupils Inspected		No. of Pupils found not to warrant a medical examination
		Satisfactory	Unsatisfactory	
		No.	No.	
(1)	(2)	(3)	(4)	(5)
1968 and later . . .	2,578	2,576	2	—
1967 . . .	10,138	10,115	23	—
1966 . . .	4,937	4,930	7	—
1965 . . .	695	690	5	—
1964 . . .	658	657	1	—
1963 . . .	386	383	3	—
1962 . . .	283	281	2	—
1961 . . .	509	509	—	3,592
1960 . . .	582	581	1	3,649
1959 . . .	272	271	1	860
1958 . . .	529	529	—	2,845
1957 and earlier . . .	361	357	4	4,299
Total . . .	21,928	21,879	49	15,245

Col. (3) total as a percentage of col. (2) total . . . 99.78

Col. (4) total as a percentage of col. (2) total . . . 0.22

Table 52 Pupils found to require treatment at periodic medical inspections (excluding dental diseases and infestation with vermin)

Age Groups Inspected (by year of birth) (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total individual pupils (4)
1968 and later	54	312	343
1967	260	570	729
1966	127	636	708
1965	32	36	57
1964	40	32	67
1963	45	16	52
1962	13	22	31
1961	23	29	47
1960	25	30	49
1959	9	14	23
1958	24	12	28
1957 and earlier	29	17	44
Total	681	1,726	2,178

Table 53 Other inspections

NOTES : A special inspection is one that is carried out at the special request of a parent, doctor, nurse, teacher, or other person.

A re-inspection is an inspection arising out of one of the periodic medical inspections or out of a special inspection.

Number of special inspections	2,709
Number of re-inspections	18,629
Total	<u>21,338</u>

Part II—Defects found by medical inspection during the year**Table 54 Infestation with vermin**

(a) Total number of individual examinations of pupils in schools by school nurses or other authorized persons	212,922
(b) Total number of individual pupils found to be infested	579
(c) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	159
(d) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	

Table 55 Special inspections

NOTE : All defects, including defects of pupils at nursery and special schools, noted at special medical inspections should be included in this Table, whether or not they were under treatment or observation at the time of the inspection.

Defect Code No. (1)	Defect or Disease (2)	SPECIAL INSPECTIONS	
		Pupils requiring Treatment (3)	Pupils requiring Observation (4)
4	Skin	11	27
5	Eyes—		
	(a) Vision	63	18
	(b) Squint	6	9
	(c) Other	5	5
6	Ears—		
	(a) Hearing	82	33
	(b) Otitis Media	3	7
	(c) Other	1	4
7	Nose and Throat	10	38
8	Speech	6	35
9	Lymphatic Gland	—	7
10	Heart	1	7
11	Lungs	15	28
12	Developmental—		
	(a) Hernia	—	3
	(b) Other	8	11
13	Orthopaedic—		
	(a) Posture	1	13
	(b) Feet	14	22
	(c) Other	7	15
14	Nervous System—		
	(a) Epilepsy	6	3
	(b) Other	5	11
15	Psychological—		
	(a) Development	78	64
	(b) Stability	35	58
16	Abdomen	5	16
17	Other	11	59

Table 56 Periodic inspections

NOTE: All defects, including defects of pupils at nursery and special schools, noted at periodic medical inspections should be included in this Table, whether or not they were under treatment or observation at the time of the inspection. This table should include separately the number of pupils found to require treatment (T) and the number of pupils found to require observation (O).

Defect Code No. (1)	Defect or Disease (2)	PERIODIC INSPECTIONS									
		Entrants		Leavers		Others		Total			
		T (3)	O (4)	T (5)	O (6)	T (7)	O (8)	T (9)	O (10)		
4	Skin . . .	208	560	1	19	13	95	222	674		
5	Eyes— (a) Vision . . . (b) Squint . . . (c) Other . . .	429 218 29	423 240 102	52 2 —	14 1 3	200 21 6	123 41 24	681 241 35	560 282 129		
6	Ears— (a) Hearing . . . (b) Otitis Media (c) Other . . .	210 127 16	809 541 101	5 1 —	9 4 1	35 6 —	89 58 21	250 134 16	907 603 123		
7	Nose and Throat . . .	234	1,350	6	16	19	142	259	1,508		
8	Speech . . .	162	700	—	7	13	75	175	782		
9	Lymphatic Glands . . .	18	524	—	7	2	48	20	579		
10	Heart . . .	22	272	2	3	2	43	26	318		
11	Lungs . . .	115	502	3	11	16	91	134	604		
12	Developmental— (a) Hernia . . . (b) Other . . .	35 49	70 366	1 1	— 14	3 11	15 59	39 61	85 439		
13	Orthopaedic— (a) Posture . . . (b) Feet . . . (c) Other . . .	11 60 38	110 403 238	1 — 2	16 15 15	2 8 10	35 65 60	14 68 50	161 483 313		
14	Nervous System— (a) Epilepsy . . . (b) Other . . .	20 15	81 104	1 1	3 6	12 —	16 37	33 16	100 147		
15	Psychological— (a) Development (b) Stability . . .	27 48	651 754	1 1	5 18	9 7	143 138	37 56	799 910		
16	Abdomen . . .	28	105	—	9	4	41	32	155		
17	Other . . .	32	206	1	6	5	56	38	268		

Part III—Treatment of pupils attending maintained primary and secondary schools (including nursery and special schools)

NOTES : This part of the return should be used to give the total numbers of :—

- (i) Cases treated or under treatment during the year by members of the Authority's own staff ;
- (ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board ; and
- (iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Table 57 Eye diseases, defective vision, and squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	263
Errors of refraction (including squint)	6,642
Total	6,905
Number of pupils for whom spectacles were prescribed .	2,245

Table 58 Diseases and defects of ear, nose, and throat

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	120
(b) for adenoids and chronic tonsillitis	323
(c) for other nose and throat conditions	100
Received other forms of treatment	283
Total	826
Total number of pupils in schools who are known to have been provided with hearing aids—	
* (a) in 1972	92
(b) in previous years	331

* A pupil recorded under (a) above should not be recorded at (b) in respect of the supply of a hearing aid in a previous year.

Table 59 Orthopaedic and postural defects

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments .	187
(b) Pupils treated at school for postural defects	35
Total	222

Table 60 Diseases of the skin (excluding uncleanness)

	Number of cases known to have been treated
Ringworm—(a) Scalp	—
(b) Body	—
Scabies	12
Impetigo	7
Other skin diseases	4,168
Total	4,187

Table 61 Child guidance treatment

	Number of cases known to have been treated
Pupils treated at Child Guidance clinics	1,224

Table 62 Speech therapy

	Number of cases known to have been treated
Pupils treated by Speech Therapists	2,017

Table 63 Other treatment given

	Number of cases known to have been dealt with
(a) Pupils with minor ailments	50
(b) Pupils who received convalescent treatment under School Health Service arrangements	16
(c) Pupils who received B.C.G. vaccination	17,996
(d) Other than (a), (b) and (c) above.	
Please specify :	
Abdomen 43	
Lungs 256	
Epilepsy 14	
Appendicitis 63	
Heart 69	
Asthma 11	
Other 1,308	
	1,764
Total (a)–(d)	19,826

V Staff

Staff as at 1st January, 1973

County Medical Officer
Deputy County Medical Officer
Medical director, Health information and research unit
Chief administrative officer
Principal dental officer
Consultant psychiatrist
 (part-time)

Divisional medical officers:

Dacorum

East Herts

North Herts

St. Albans

South-West Herts

Welwyn

Deputy Divisional Medical Officers:

Dacorum

East Herts

North Herts

St. Albans

South-West Herts

Welwyn

Chest Physicians

Divisional dental officers

Orthodontists

Director of Nursing Services

Principal nursing officers

Community health teacher

Assistant training officer

Divisional nursing officers:

Dacorum

East Herts

North Herts

St. Albans

South West Herts

Welwyn

County health inspector

Deputy county health inspector

County health education officer

Statistician

Senior speech therapist

County dietitian

G. W. Knight, M.D., D.P.H.

F. Seymour, M.B., Ch.B., M.F.C.M., D.P.H.

G. Cust, M.B., Ch.B., M.F.C.M., D.P.H., D.T.M. & H.

W. A. Treharne, F.C.I.S., F.H.A.

A. H. Millett, L.D.S., R.C.S.

J. L. McClure, M.B., B.S., D.P.M., M.R.C.P.

R. S. Hynd, M.B., Ch.B., D.P.H., Town Hall, Marlowes, Hemel Hempstead.

J. V. Earle, M.A., M.B., B.Ch., M.F.C.M., D.P.H., D.I.H., Council Offices, High Street, Hoddesdon.

J. D. Hall, M.R.C.S., L.R.C.P., M.F.C.M., D.P.H., Bedford Road, Hitchin.

W. Norman-Taylor, M.D., D.P.H., D.I.H., Bleak House, Catherine Street, St. Albans.

A. Shaw, M.B., B.S., D.P.H., M.F.C.M., Town Hall, Watford.

G. R. Taylor, M.B., B.S., D.P.H., M.F.C.M., "Gooseacre," Cole Green Lane, Welwyn Garden City.

S. J. Gardiner, M.B., B.Sc., Ch.B., M.F.C.M.

E. C. Howarth, M.B., B.S., D.P.H.

W. W. Cowen, O.B.E., M.R.C.S., L.R.C.P., D.P.H., D.T.M. & H.

P. B. M. O'Reilly, M.R.C.S., L.R.C.P., D.P.H.

F. Barasi, M.R.C.S., L.R.C.P., D.P.H., M.F.C.M.

E. P. Rigby, M.B.E., M.B., B.S., M.F.C.M., D.P.H., D.T.M., & H.

J. H. Angel, M.D., M.R.C.P.

T. A. W. Edwards, B.A., M.B., B.Ch., M.R.C.P.

A. G. Hounslow, M.D.

E. Rhys Jones, M.B., B.Sc., M.R.C.P.

V. U. Lutwyche, M.A., M.D., M.R.C.P., D.C.H.

N. MacDonald, M.B., Ch.B., F.R.C.P.

A. Pines, M.A., M.D., M.R.C.P.

P. W. Roe, B.A., B.M., B.Ch.

L. M. J. Ewart, L.D.S.

P. C. Perkins, B.D.S., L.D.S., D.D.P.H., R.C.S.

D. Caplan, B.D.S., L.D.S., R.C.S.

D. H. Silver, L.D.S., D.D.P.H., R.C.S.

R. J. Smee, L.D.S., D.D.P.H., R.C.S.

P. M. Tanner, L.D.S., R.C.S.

J. F. Crawford, L.D.S., D.Orth., R.C.S.

S. J. Zaufal, B.D.S., D.Orth., R.C.S.

D. E. M. Warner, L.D.S., R.C.S., D.D.O.

V. M. King, S.R.N., S.C.M., H.V., Q.N.

D. D. Cantrill, S.R.N., S.C.M., D.N., H.V.

D. H. Wagner, S.R.N., S.C.M., H.V., Q.N.

G. M. Abbott, S.R.N., S.C.M., H.V., Dip. Sociology

J. Williams, S.R.N., S.C.M., H.V.

M. E. James, S.R.N., S.C.M., H.V., Q.N.

M. J. Elliott, S.R.N., S.C.M., H.V., Q.N.

C. Bissell, S.R.N., S.E.N., S.C.M., H.V.

M. E. Pritchard, S.R.N., S.C.M., H.V., Q.N.

J. L. Stringer, F.I.P.H.E., M.R.S.H., F.A.P.H.I.

W. S. Biggins, M.A.P.H.I., A.M.Inst.P.C.

M. Evans, S.R.N., Certificate in Content and Method of Health Education

V. A. Dickinson, B.Sc.

M. Evesham, M.Sc., L.C.S.T.

J. Okell, B.Sc., S.R.D.

<i>Medical officers (salaried)</i>	19 whole-time and 10 part-time medical officers were employed (equivalent 25·4 whole-time) In addition, a number of fee-paid part-time medical officers were employed.
<i>Dental officers (salaried)</i>	6 whole-time and 3 part-time dental officers were employed (equivalent 8·2 whole-time). In addition, 29 fee-paid part-time dental officers were employed.
<i>Dental auxiliaries</i>	7 whole-time dental auxiliaries were employed.
<i>Dental surgery assistants</i>	18 whole-time and 43 part-time dental surgery assistants were employed.
<i>Speech therapists</i>	24 speech therapists were employed (equivalent 16·2 whole-time).
<i>Chiropodists</i>	1 full-time chiropodists was employed + 1 trainee at London Foot Hospital
<i>Orthoptists</i>	7 orthoptists were employed (equivalent 3·8 whole-time).
<i>Audiometricians</i>	6 audiometricians were employed (equivalent 5·5 whole-time)
<i>Health education officers</i>	4 whole-time and 2 part-time health education officers were employed (equivalent to 5 whole-time).

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